



**The Mental Retardation Home and Community-Based  
1915(c) Waiver Application**

**Effective July 1, 2004**

**The Commonwealth of Virginia  
Virginia Department of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219**

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## SECTION 1915(c) WAIVER REQUEST

1. The State of Virginia requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

This is a request for a model waiver.

a. Yes

b. XX No

If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

This waiver is requested for a period of (check one):

a. 3 years (initial waiver)

b. XX 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following level(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

a. Nursing facility (NF)

b. XX Intermediate care facility for mentally retarded or persons with related conditions  
(ICF/MR)

c. \_\_\_\_\_ Hospital

d. \_\_\_\_\_ NF (served in hospital)

e.\_\_\_\_\_ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

a. \_\_\_\_\_ aged (age 65 and older)

b. \_\_\_\_\_ disabled

c. \_\_\_\_\_ aged and disabled

d. X                      mentally retarded

e. \_\_\_\_\_ developmentally disabled

g.\_\_\_\_\_ chronically mentally ill

a. XX Waiver services are limited to the following age groups (specify):  
Individuals with a diagnosis of mental retardation age 6 and older and  
individuals up to age 6 who are at risk of developmental delay.

c.\_\_\_\_\_ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

e.            Not applicable.

6. This waiver program includes individuals who are eligible under medically needy groups.

a. \_\_\_\_\_ Yes                      b. XX No

a.        Yes                      b. XX No                      c.        N/A

a. Yes                      b. XX No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a.      Yes

b. XX No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a.      Case management

b.      Homemaker

c.      Home health aide services

d. XX Personal assistance services

e. XX Respite care

f.      Adult day health

g. XX Habilitation

XX Residential Support

XX Day Support

XX Prevocational services

XX Supported employment services

     Educational services

h. XX Environmental accessibility adaptations - Called "Environmental Modifications" in Virginia

i. XX Skilled nursing

j.      Transportation

k. XX Specialized medical equipment and supplies - Called "Assistive Technology" in Virginia

- l. ☐ Chore services
- m. ☒ Personal Emergency Response Systems
- n. ☒ Companion services
- o. ☐ Private duty nursing
- p. ☐ Family/Caregiver training
- q. ☐ Attendant care
- r. ☐ Adult Residential Care
- ☐ Adult foster care
- ☐ Assisted living
- s. ☐ Extended State plan services (Check all that apply):
- ☐ Physician services
- ☐ Home health care services
- ☐ Physical therapy services
- ☐ Occupational therapy services
- ☐ Speech, hearing and language services
- ☐ Prescribed drugs
- ☐ Other (specify):
- t. ☒ Other services (specify):
- ☒ Crisis Stabilization
- ☒ Therapeutic Consultation
- u. ☐ The following services will be provided to individuals with chronic mental illness:
- ☐ Day treatment/Partial hospitalization
- ☐ Psychosocial rehabilitation
- ☐ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.
13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.
14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.
15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):
- a. XX When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).
  - b.      Meals furnished as part of a program of adult day health services.
  - c.      When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to CMS:
- a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:
    - 1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);
    - 2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
- b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.
- c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:
  1. Informed of any feasible alternatives under the waiver; and
  2. Given the choice of either institutional or home and community-based services.
- d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.
- e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.
- f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.
- g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.
- h. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.
- i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. XX Yes                      b.      No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to CMS at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a.      Yes                      b. XX No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of July 1, 2004 is requested.

20. The State contact person for this request is Diana Thorpe, who can be reached by telephone at (804) 692-0481.

21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: Patrick W. Finnerty

Print Name: Patrick W. Finnerty

Title: Director

Date: March 31, 2004

## APPENDIX A - ADMINISTRATION

### LINE OF AUTHORITY FOR WAIVER OPERATION

#### CHECK ONE:

\_\_\_\_\_ The waiver will be operated directly by the \_\_\_\_\_ of the Medicaid agency.

XX The waiver will be operated by Department of Mental Health, Mental Retardation and Substance Abuse Services, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver; issues policies, rules and regulations related to the waiver; and makes payment for waiver services provided through the Medicaid Management Information System. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

\_\_\_\_\_ The waiver will be operated by \_\_\_\_\_, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

## APPENDIX B - SERVICES AND STANDARDS

### APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

#### a. \_\_\_\_ Case Management

\_\_\_\_ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case Management shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1. \_\_\_\_ Yes                      2. \_\_\_\_ No

Case Managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1. \_\_\_\_ Yes                      2. \_\_\_\_ No

\_\_\_\_ Other Service Definition (Specify):

#### b. \_\_\_\_ Homemaker:

\_\_\_\_ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

\_\_\_\_ Other Service Definition (Specify):

#### c. \_\_\_\_ Home Health Aide services:

\_\_\_\_ Services defined in 42 CFR 440.70, with the exception that limitations on /or State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given

in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

\_\_\_\_ Other Service Definition (Specify):

d. XX Personal assistance services:

XX Providing assistance with Activities of Daily Living (ADL): eating, bathing, dressing, transferring, and toileting, it includes medication monitoring and monitoring health status and physical condition. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to the Virginia Administrative Code 18VAC90-20-420 through 18VAC90-20-460. When specified in the plan of care, personal assistance services may include assistance with Instrumental Activities of Daily Living (IADLs), such as bedmaking, dusting, vacuuming, shopping, and preparation of meals, but does not include the cost of the meals themselves. Assistance with IADLs must be essential to the health and welfare of the individual, rather than the individual's family. These services substitute for the absence, loss, diminution, or impairment of a physical, behavioral, or cognitive function. Provision of these services is not limited to the home.

An additional component to personal assistance is work- or school-related personal assistance. This allows the personal assistance provider to provide assistance and supports for individuals in the workplace and for those individuals attending post-secondary educational institutions. This service is only available to individuals who also require personal assistance services to meet their ADLs. Workplace or school supports through the MR Waiver are not provided if they are services provided by the Department of Rehabilitative Services, under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act or Section 504 of the Rehabilitation Act. Work related personal assistance services do not duplicate services provided under supported employment.

This service is agency-directed and consumer-directed. Please refer to Attachment B:1-1 for an overview of the consumer-directed model of this service.

1. Services provided by family members (Check one):

\_\_\_\_ Payment will not be made for personal care services furnished by a member of the individual's family.

XX Personal assistance providers may be members of the individual's family. Payment will not be made for services furnished by spouses or parents of minor children. Payment will not be made for services furnished by other family members unless there is objective, written documentation as to why there are no other providers available to provide the care.

Justification attached. (Check one):

XX Family members who provide personal assistance services must meet the same standards as providers who are unrelated to the individual.

\_\_\_ Standards for family members providing personal assistance services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

XX A registered nurse, licensed to practice nursing in the State.

XX A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

\_\_\_ Case managers

XX Other (Specify):  
Designated supervisors of residential services licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS).

3. Frequency or intensity of supervision (Check one):

\_\_\_ As indicated in the plan of care

XX Other (Specify):  
A registered nurse, licensed practical nurse, or a supervisor of residential services licensed by DMHMRSAS.

shall make supervisory visits as often as needed between reassessments to ensure both quality and appropriateness of services. The minimum frequency of these visits is every 30 – 90 days, depending on the needs of the recipient.

4. Relationship to State plan services (Check one):

- XX Personal assistance services are not provided under the approved State plan.
- Personal care services are included in the State plan, but with limitations. The waived service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.
- Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

       Other service definition (Specify):

Supervision (Check all that apply):

- Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.
- Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific Consumer-Directed Personal Assistance Service provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.
- Other supervisory arrangements (Specify):

e. XX Respite care

XX Services provided in the home and community to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those unpaid persons normally providing the care.

This service is agency-directed and consumer-directed. Please refer to Attachment B:1-1 for an overview of the consumer-directed model of this service.

\_\_\_ Other service definition (Specify):

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

XX Individual's home or place of residence (agency and consumer-directed models)

\_\_\_ Foster home

\_\_\_ Medicaid certified Hospital

\_\_\_ Medicaid certified NF

XX Medicaid certified ICF/MR (agency-directed model only)

XX Group home (agency-directed model only)

XX Licensed respite care facility (agency-directed model only)

XX Other community care residential facility licensed by DMHMRAS  
Sponsored Residential Services (agency-directed model only)

\_\_\_ Other service definition (Specify):

f. \_\_\_ Adult day health:

\_\_\_ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and

speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1. ☐ Yes                      2. ☐ No

☐ Other service definition (Specify):

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g. XX                      Habilitation:

XX                      Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

XX                      Congregate Residential Support: assistance with acquisition, retention or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, access into the community, and the social and adaptive skills necessary to ensure health and safety and enable the individual to reside in a non-institutional setting.

Payments for congregate residential supports are not made for room and board, the cost of administering a facility or group home, or the costs of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential support does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family member or a group home provider or for activities or supervision for which a payment is made by a source other than Medicaid. Congregate residential support is paid as an hourly rate. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G (Attachment G:3-1).

XX

Day Support: assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills which typically takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished one or more hours per day on a regularly scheduled basis, for one or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day Support services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech/language therapies listed in the plan of care. In addition, day support services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

XX

Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as ~~compliance~~ accepting supervision, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force without supports or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Check one:

\_\_\_ Individuals will not be compensated for prevocational services.

XX When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

— Educational services, which consist of special education and related services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

XX

Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. ~~The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.~~

1. X Yes                      2.    No

XX Other service definition (Specify):

In-Home Residential Supports: Virginia uses the service description in Attachment B:1-2 in lieu of the waiver application description.

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. XX Environmental accessibility adaptations: (Virginia regulations refer to this service as "Environmental Modifications")

XX Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or

improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes. Modifications can be made to a vehicle if it is the primary vehicle being used by the individual. Individuals will be allowed up to, but not to exceed, \$5,000 per year for environmental modifications.

\_\_\_\_ Other service definition (Specify):

i. XX Skilled nursing:

XX ~~Part-time or intermittent care.~~ Services listed in the plan of care that do not meet home health criteria; which are within the scope of the State's Nurse Practice Act; and are provided by a registered professional nurse, or licensed practical ~~or vocational~~ nurse under the supervision of a registered nurse, licensed to practice in the State. Skilled nursing services are to be used to provide training, consultation, nurse delegation as appropriate, and oversight of direct care staff as appropriate.

\_\_\_\_ Other service definition (Specify):

j. \_\_\_\_\_ Transportation:

\_\_\_\_ Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

\_\_\_\_ Other service definition (Specify):

k. XX Specialized Medical Equipment and Supplies: (Virginia regulations refer to this service as "Assistive Technology"):

XX

Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation. Individuals will be allowed up to, but not to exceed, \$5,000 per year for assistive technology.

\_\_\_\_ Other service definition (Specify):

1. \_\_\_\_ Chore services:

\_\_\_\_ Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

\_\_\_\_ Other service definition (Specify):

m. XX Personal Emergency Response Systems (PERS)

XX

PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. When medically appropriate, the PERS device can be combined with a medication monitoring system to monitor medication compliance.

\_\_\_\_ Other service definition (Specify):

n. XX Adult companion services:

XX Non-medical care, supervision and socialization, provided to an adult. Companions may assist or supervise the individual with such tasks as meal preparation, community access, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

This service is agency-directed and consumer-directed. Please refer to Attachment B:1-1 for an overview of the consumer-directed model of this service.

\_\_\_\_ Other service definition (Specify):

o. \_\_\_\_ Private duty nursing:

\_\_\_\_ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

\_\_\_\_ Other service definition (Specify):

p. \_\_\_\_ Family/Caregiver training:

\_\_\_\_ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

\_\_\_\_ Other service definition (Specify):

q. \_\_\_\_ Attendant care services:

\_\_\_\_ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped persons with mental retardation. If recipients are not able to demonstrate their ability to independently manage their own personal assistants, a family caregiver will

also be eligible to utilize this form of service on behalf of the recipient. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

\_\_\_\_ Other service definition (Specify):

r. \_\_\_\_ Adult Residential Care (Check all that apply):

\_\_\_\_ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

\_\_\_\_ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living

unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume

responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

- ☐ Home health care
- ☐ Physical therapy
- ☐ Occupational therapy
- ☐ Speech therapy
- ☐ Medication administration
- ☐ Intermittent skilled nursing services
- ☐ Transportation specified in the plan of care
- ☐ Periodic nursing evaluations
- ☐ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour

skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

☐ Other service definition (Specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s. XX Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

1. Therapeutic Consultation: For recipients who have additional challenges restricting their ability to function in the community. Therapeutic consultation may be provided in the

recipient's home or any community setting. Therapeutic Consultation includes activities that assist the individual, family/caregivers, or service providers in implementing an individual program plan through:

Evaluation of a recipient's psychological, behavioral, physical, speech and language and/or social functioning and assessment of current treatment, program of therapy or interventions, training modalities and/or behavioral approaches;

Consultation, training and technical assistance to individuals who provide a recipient with services and supports to enhance psychological, behavioral, physical, speech and language and/or social functioning of the recipient;

Assessment of the recipient's need for and ability to benefit from environmental modifications and/or special medical equipment and supplies;

Technical assistance to individuals who provide a recipient with services and supports in selecting appropriate environmental modifications and/or equipment and devices and in facilitating appropriate use by the recipient.

Activities not included in therapeutic consultation are ongoing therapy and monitoring activities. Evaluation, assessment and consultation provided by staff of the residential or day support setting may not be billed separately as therapeutic consultation.

2. Crisis Stabilization: Direct intervention to individuals who are experiencing serious psychiatric or behavioral problems which jeopardize their current situation by providing temporary intensive services and supports that avert emergency psychiatric hospitalization, institutional placement or loss of a community service. This service must stabilize the individual and strengthen the current situation so that the individual can be maintained in the community during and beyond the crisis period. Services will include as appropriate, psychiatric, neuropsychiatric and psychological assessment and other functional assessments and stabilization techniques; medication management and monitoring; behavior assessment and support; intensive care coordination with other agencies and providers to assist planning and delivery of services and supports to maintain the individual; training of family members, other caregivers and service providers on how to support the individual to maintain the individual in the community; and temporary crisis supervision to ensure the safety of the individual and others.

Crisis Stabilization services may not be used for continuous long-term care. Room and board and general supervision are not components of this service. To receive crisis stabilization services, the individual must meet at least one of the following criteria:

- a. Is experiencing marked reduction in psychiatric, adaptive, or behavioral functioning;
- b. Is experiencing extreme increase in emotional distress;
- c. Needs continuous intervention to maintain stability; or
- d. Is causing harm to self or others.

The individual must be at risk of at least one of the following:

- a. Psychiatric hospitalization;
- b. Emergency ICF/MR placement;
- c. Immediate threat of loss of a community service (residential, day support, personal assistance, etc.) due to severe situational reaction (i.e., change in schedule/staff/medication); or
- d. Causing harm to self or others.

Crisis Stabilization services must be authorized following a documented face-to-face assessment conducted by a qualified mental retardation professional. If appropriate, the assessment will be conducted jointly with a licensed mental health professional or other appropriate professional(s), or both. The actual service units per episode will be based on the documented clinical needs of the individual being served.

### 3. Crisis Supervision:

Crisis Supervision is an optional component of Crisis Stabilization in which one-to-one supervision of the individual in crisis is provided by agency staff in order to ensure the safety of the individual and others in the environment. Crisis Supervision may be provided as a component of crisis stabilization only if clinical or behavioral interventions allowed under this service are also provided during the authorized period. Crisis Supervision must be provided one-to-one and face-to-face with the individual.

t. \_\_\_\_\_ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

- \_\_\_\_ Physician services
- \_\_\_\_ Home health care services
- \_\_\_\_ Physical therapy services
- \_\_\_\_ Occupational therapy services
- \_\_\_\_ Speech, hearing and language services

\_\_\_ Prescribed drugs

\_\_\_ Other State plan services (Specify):

u. \_\_\_ Services for individuals with chronic mental illness, consisting of (Check one):

\_\_\_ Day treatment or other partial hospitalization services (Check one):

\_\_\_ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

- a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),
- b. occupational therapy, requiring the skills of a qualified occupational therapist,
- c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,
- d. drugs and biologicals furnished for therapeutic purposes,
- e. individual activity therapies that are not primarily recreational or diversionary,
- f. family counseling (the primary purpose of which is treatment of the individual's condition),
- g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
- h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

\_\_\_ Other service definition (Specify):

\_\_\_ Psychosocial rehabilitation services (Check one):

\_\_\_ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- b. social skills training in appropriate use of community services;
- c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

- a. vocational services,
- b. prevocational services,
- c. supported employment services, and
- d. room and board.

\_\_\_ Other service definition (Specify):

\_\_\_ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

\_\_\_ This service is furnished only on the premises of a clinic.

\_\_\_ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

## Attachment B: 1-1

### **Overview of Consumer Direction in the Mental Retardation Waiver**

#### **Mental Retardation (MR) Waiver**

This waiver is designed to serve individuals under six years of age who are at developmental risk and individuals who have a diagnosis of mental retardation. These individuals must meet the level of care criteria for an ICF/MR. The waiver includes an array of services to assist individuals to remain in their homes and communities instead of facing institutional placements.

#### **Consumer Directed Services**

The MR Waiver offers consumer directed models of service delivery for personal assistance, respite care, and adult companion services in addition to the traditional agency directed model of service delivery. Consumer direction for these services means that the individual is the employer; the individual is responsible for hiring, training, supervising, and firing consumer-directed employees. If the individual is a minor, or unable to handle the responsibilities related to being an employer, a family/caregiver may assume these responsibilities on behalf of the individual. Specific employer duties include checking potential employee references, determining that the potential employee meet the provider qualifications, submitting employee completed paperwork to the fiscal agent, training the employee, supervising the employee's performance, and confirming/submitting the employee's timesheets to the fiscal agent. The individual must have a viable back –up plan in the event the employee cannot work for whatever reason. Individuals who do not have a viable back –up plan are not eligible for this service delivery option. Qualifications of consumer-directed employees are described in Exhibit B of Appendix B-2.

Supervision of the consumer-directed employee is furnished directly by the recipient or the family/caregiver with consultation by the case manager and the consumer-directed (CD) Services Facilitator as needed. The recipient or family/caregiver, upon entry into the service, will receive management training by the CD Services Facilitator. During visits with the recipient, the CD Services Facilitator must observe, evaluate, and consult with the individual or family/caregiver, and document the adequacy and appropriateness of consumer-directed services with regard to the recipient's current functioning and cognitive status, medical and social needs. CD Service Facilitator requirements are described in Exhibit A of Appendix B-2.

#### **Service Facilitation**

Service Facilitation is an administrative function that is available through the MR Waiver for individuals who choose to use the consumer directed service delivery model. A Service Facilitator assists the individual and/or family/caregiver as they become employers for consumer directed services. This function includes providing the individual and/or family/caregiver with management training, review and explanation of the Employee Management Manual, and routine visits to monitor the employment process. A consumer directed employee registry is maintained by the Service Facilitator to assist with the recruitment process if needed. The Service Facilitator assists the individual with submitting required paperwork to the fiscal agent so the individual is formally considered the "employer."

The Service Facilitator assists with the initiation of consumer directed services by completing a criminal record check on the potential employee (and a Child Protective Services screening if appropriate) and reporting the results to the employer and the fiscal agent. The Service Facilitator reviews the employee timesheets during face-to-face visits every six months to ensure the services are delivered as required in the approved Individual Service Plan. Discrepancies are addressed with the individual and/or family/caregiver and reported to the fiscal agent as needed. The Service Facilitator must report consistent discrepancies to the Case Manager to address with the individual and/or family/caregiver for resolution. The Service Facilitator assists the individual/employer with training the consumer directed employee, or may train the employee on behalf of the individual/employer. The Service Facilitator monitors the employment process and works with the individual/employer on employer issues as they arise.

Service Facilitators must maintain certain records per DMAS requirements.

### **Fiscal Agent**

The fiscal agent provides an administrative function that is available through the MR Waiver for individuals who choose to use the consumer directed service delivery model. Having a fiscal agent recognized by the IRS, allows the individual to participate in consumer directed services while being assured that all employment tax responsibilities are properly handled. This function includes taking appropriate actions to file/register the individual as an employer. The fiscal agent conducts payroll activities for the consumer directed employee on behalf of the individual/employer. Employee timesheets are submitted to the fiscal agent by the individual/employer for payment. The fiscal agent prepares reports and maintains records as required.

### **Case Manager**

For Consumer Directed Services, the case manager assesses the individual who has requested consumer directed services to determine the ability to be an employer of consumer directed services. Upon completion of the assessment and explanation of consumer directed services, the case manager provides the individual and/or family/caregiver with a list of Service Facilitators. The case manager may actively link the individual to the Service Facilitator selected by the individual and/or family/caregiver. The Case Manager may also be a Service Facilitator, but must meet the provider requirements for both functions as well as perform the service/function as required for both roles.

Case management services include assessing and reassessing the individual, the appropriateness of services, and the individual's satisfaction with services; planning, coordinating and monitoring services; linking the individual to services and supports; and making collateral contacts (including the Service Facilitator). Case management service requirements are more fully described in the regulations. All case management tasks and requirements apply to consumer directed services as well as agency directed services.

The case manager must be actively involved in monitoring consumer-directed services, in conjunction with the employer supervision provided by the individual, in order to ensure quality of care and to protect the health and safety of the individual. The case manager must respond to concerns raised by the individual and/or family/caregiver, the Service Facilitator, and/or the fiscal agent related to consumer directed services.

The case manager must maintain records as required.

## **Attachment B-1:2**

### **In-Home Residential Support Service Description**

In-Home Residential Support services consist of assistance with acquisition, retention or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, access into the community, and the social and adaptive skills necessary to ensure health and safety and enable the individual to live in a community setting. Emphasis is on a person-centered approach that empowers and supports each individual in developing his or her own lifestyles. In-Home Residential Support may not include room and board or general supervision. In-Home Residential Supports are paid as an hourly rate. Payments are not made for activities or supervision for which a payment is made by a source other than Medicaid.

In-Home Residential Supports are supplemental to the primary care provided by the family/caregiver. This service may also support an individual whose level of independence does not require a primary caregiver. An In-Home Residential Support staff person comes to the residence to provide services. In-Home Residential Supports are delivered on an individualized basis according to the plan of care and are delivered primarily with a 1:1 staff to individual ratio except when training protocols require parallel or interactive intervention. Services are not routinely provided by paid staff of the In-Home Residential Supports provider across a continuous 24-hour period.

#### **In-Home/Supported Living Residential Support Activities**

1. Training in functional skills related to personal care activities (toileting, bathing, grooming, dressing, eating, mobility, communication, household chores, food preparation, money management, etc.).
2. Training in functional skills related to the use of community resources (transportation, shopping, restaurants, social and recreational activities, etc.).
3. Training in adapting behavior for community and home and community environments. Examples (not all inclusive):
  - Developing a network of natural supports.
  - Handling social encounters with others.
  - Redirecting anger toward others.
4. Monitoring health and physical condition; assistance with medication and/or other medical needs.
5. Assistance with activities of daily living, instrumental activities of daily living and use of community resources, when provided incidental to needed training, as identified in the ISP:
6. Assisting with transportation to and from training sites and community resources; and
7. Providing specialized supervision to ensure the individual's health and safety.

## APPENDIX B-2 PROVIDER QUALIFICATIONS

### A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Assistive Technology (Specialized Medical Equip. & Supplies)	Durable Medical Equipment Supply Providers and Community Services Boards		12 VAC30-120-221	Individual assessments conducted by professional personnel according to expertise <u>Code of Virginia</u> , 54.1 et seq. Prior to approval of purchase
Companion Care (Agency Directed)	Personal Care providers; Home Health agencies; Providers licensed by DMHMRSAS to provide respite, day support and residential services	12 VAC 35-105 12 VAC 5-380-10 et seq.	12 VAC 30-120-223	Minimum Qualifications - See Exhibit D
Companion Care (Consumer-Directed)	Companion Aides, CD Services Facilitator			Minimum Qualifications. See Exhibits A and D to this Appendix.
Congregate Residential Support	Providers that are licensed by DMHMRSAS to provide residential services; Providers that are licensed by DMHMRSAS with a CORE license	12 VAC 35-105		Staff Orientation Workbook, Training and Test
Crisis Stabilization	Providers licensed by DMHMRSAS as Outpatient, Residential, Supportive Residential or Day Support Services licensed providers	12 VAC 35-105	12 VAC 35-105-10	Qualified Mental Retardation Professionals (must have one year experience working in the mental retardation field and a bachelors degree in human

				service field and the required license, registration, or certification in accordance with profession.)
Crisis Supervision	Providers licensed by DMHMRSAS to provide Outpatient, Residential, or Day Support services	12 VAC 35-105	12 VAC 35-105-10	
Day Support	Providers licensed by DMHMRSAS to provide Day Support Services	12 VAC 35-105		
Environmental Modifications	DME Providers enrolled with DMAS, DRS approved Providers, Rehabilitation Engineers, Community Services Boards		12 VAC30-120-230	All Applicable State or Local Building Codes
In-Home Residential Support	Providers licensed by DMHMRSAS to provide Residential services	12 VAC 35-105		Staff Orientation Workbook, Training and Test
Personal Emergency Response Systems (PERS)	DME Providers, PERS Providers (e.g., certified home health providers, hospitals)			Minimum Qualifications. See Exhibit E to this Appendix.
Personal Assistance Services (Agency Directed)	Personal Care Providers, Home Health Providers, Providers licensed by DMHMRSAS to provide Residential services	12 VAC 5-380-10 et seq.  12 VAC 35-105	12 VAC 30-120-233	Exhibit C
Personal Assistance Services	Personal Assistant, CD Services Facilitator		12 VAC 30-120-225	See Exhibits A and B

(Consumer-Directed)				
Prevocational Services	Day Support Providers licensed by DMHMRSAS or DRS approved vendors	12 VAC 35-105		
Respite Care (Agency-Directed)	Personal Care Providers, Home Health Providers, Providers licensed by DMHMRSAS to Provide Residential Services, Respite Care Providers, ICFsMR	12 VAC 35-105 12 VAC 5-380-10 et seq.	12VAC30-120-243 12VAC30-102-10	Exhibit C
Respite Care (Consumer-Directed)	Respite Assistants, CD Services Facilitator			Exhibits A and B
Skilled Nursing	Home Health Providers, Home Care Agencies, Licensed RNs hired/contracted by DMHMRSAS licensed Respite, Residential, and Day Support providers	12 VAC 5-380-10 et seq. 12 VAC-35-105 <u>Code of Virginia</u> , 54.1-2400 and 54.2-3005	12 VAC 30-120-245	
Supported Employment	DRS approved Vendors or providers with CARF certification		12 VAC 30-120-247	
Therapeutic Consultation	Psychologists, Psychiatrists, Psychiatric Clinical Nurse Specialists, Therapeutic Rec. Specialist, Licensed Professional Counselor, Behavioral Consultants, PT, OT, ST, Rehabilitation	<u>Code of Virginia</u> , 54.1 et seq.	12 VAC 30-120-249	

	Engineer, Certified Rehabilitation Specialist, L.C.S.W., Licensed Family Therapist			
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B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

## **Exhibit A**

### **Consumer Directed Services Facilitator Qualifications for Consumer-Directed Personal Assistance Services, Consumer-Directed Respite Services and Consumer-Directed Companion Services**

#### **Consumer Directed Services Facilitator Providers are:**

- An agency, organization, or individual that enrolls with DMAS as a provider of Consumer Directed Service Facilitation Services that are performed by Consumer-Directed Services Facilitators meeting the stated qualifications.

To be enrolled as a Medicaid Consumer-Directed Services Facilitation provider and maintain provider status, the following standards shall be met:

1. The agency must have sufficient qualified staff to perform the needed consumer-directed service facilitation and support activities as required by the Consumer-Directed Respite, Companion and/or Consumer-Directed Personal Assistance Services programs. The staffing ratio will be one full-time Consumer-Directed (CD) Services Facilitator for every 35 recipients. The CD service facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. The CD service facilitator must have these knowledge, skills, and abilities at the entry level that must be documented or observable in the application form, or supporting documentation or in the interview (with appropriate documentation). The knowledge, skills, and abilities shall be, but not necessarily limited to:
  - Knowledge of:
    - a. Types of functional limitations and health problems that may occur in persons with mental retardation as well as strategies to reduce limitations and health problems;
    - b. Physical assistance that may be required by people with mental retardation, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;
    - c.. Equipment and environmental modifications that may be required by people with mental retardation which reduces the need for human help and improve safety;
    - d. Various long-term care program requirements, including ICF/MR placement criteria, Medicaid Waiver services, and other federal, state, and local resources that provide personal assistance services, respite, and companion services;
    - e. DMAS Consumer-Directed Personal Assistance Services, Consumer-Directed Respite Care, and Companion Care service program requirements, as well as the administrative duties for which the recipient will be responsible;
    - f. Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in care planning;
    - i. Interviewing techniques;
    - j. The recipient's right to make decisions about, direct the provisions of, and control his services, including hiring, training, managing, approving time sheets, and firing an assistant/companion;

k. The principles of human behavior and interpersonal relationships; and

l. General principles of record documentation.

- Skills in:

- a. Negotiating with recipients, family/caregivers and service providers;
- b. Observing, recording, and reporting behaviors;
- c. Identifying developing, and/or providing services to persons with mental retardation; and
- d. Identifying services within the established services system to meet the recipient's needs;

- Abilities to:

- a. Report findings of the assessment or onsite visit, either in writing or an alternative format for persons who have print impairments.
- b. Demonstrate a positive regard for recipients and their families;
- c. Be persistent and remain objective;
- d. Work independently, performing position duties under general supervision;
- e. Communicate effectively, verbally and in writing;
- f. Develop a rapport and communicate with different types of persons from diverse cultural backgrounds; and
- g. Interview.

Individuals meeting all the above qualifications may be considered a CD Services Facilitator; however, it is preferred that the CD Services Facilitator possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the CD Services Facilitator has two years of satisfactory experience in the human services field working with persons with mental retardation.

2. If the CD Services Facilitation provider is not a Registered Nurse, the CD Services Facilitator must inform the primary health care provider (i.e., physician) that services are being provided and request consultation as needed.

## **Exhibit B**

### **Consumer-Directed Personal Assistance Services/Consumer-Directed Respite Care Assistant Requirements**

#### ***Individuals Who Are Employed by the Recipient Under A Consumer-Directed Model of Care***

Qualifications. The Assistant must:

- Be 18 years of age or older;
- Possess basic reading, writing and math skills;
- Have a valid Social Security Number;
- Have the required skills to perform Consumer-Directed Personal Assistance or Consumer-Directed Respite services as specified in the recipient's Individual Service Plan;
- Submit to a criminal history record check and submit to a record check under the State's Child Protective Services Registry. The personal assistant will not be compensated for services provided to the recipient or family/caregiver and will be dismissed by the recipient or family/caregiver after the records check verifies the personal assistant has been convicted of crimes described in the Code of Virginia, § 37.1-183.3 and § 37.1-197.2.
- Be willing to attend training (i.e., safety training) at the recipient or family/caregiver's request;
- Receive periodic TB screening, CPR training, and an annual flu immunization (unless medically contraindicated); and
- Understand and agree to comply with the Consumer-Directed Personal Assistance Services and Consumer-Directed Respite Service requirements.

Personal assistants shall not be spouses or parents of minor children. Payment will not be made for services furnished by other family members living under the same roof as the individuals receiving services unless there is objective, written documentation as to why there are no other providers available to provide the service.

## Exhibit C

### Personal/Respite Care Agency Provider Requirements

A Mental Retardation Waiver Services Participation Agreement to provide Personal Assistance services must be obtained from DMAS, except for those agencies that have a DMAS Participation Agreement to provide Personal Care services. DMAS-certified Personal Care agencies may provide MR Waiver Personal Assistance under that agreement.

The following types of providers can deliver Personal Assistance/Respite Services:

1. Certified by DMAS as a Personal Care Provider agency

Individuals who provide care must meet the requirements of DMAS Personal/Respite Care Assistant. Basic qualifications for Personal/Respite Care Assistants include the:

- Physical ability to do the work;
- Ability to read and write;
- Completion of a training curriculum consistent with DMAS requirements. Prior to assigning an assistant to a consumer, the provider agency must obtain documentation that the assistant has satisfactorily completed a training program consistent with DMAS requirements. DMAS requirements may be met in one of three ways:
  - (a) Registration as a Certified Nurse Assistant; or
  - (b) Graduation from an approved educational curriculum which offers certificates qualifying the student as a Nursing Assistant, Geriatric Assistant, or Home Health Assistant; or
  - (c) Provider-offered training, which is subject to prior approval from DMAS.

2. Licensed by DMHMRSAS as a provider of Residential Services or Supportive Residential Services.

Providers must also assure and document that persons providing Personal Assistance services have received training in the characteristics of mental retardation and appropriate interventions, training strategies, and other methods of supporting individuals with functional limitations. Within 30 days of beginning to provide MR Waiver services, any individual providing direct care must review the DMHMRSAS *Mental Retardation Staff Orientation Workbook* with the program supervisor or trainer and successfully complete the accompanying test by answering correctly 56 questions or more.

It is the responsibility of the provider to assure that the *Orientation Workbook* is administered according to the following:

1. The program supervisor or trainer must have received training on the use of the *Orientation Workbook* by a DMHMRSAS-trained individual or by viewing the supervisor training video;

2. The program supervisor or trainer should review the content of the workbook prior to training and testing direct support staff;
3. The program supervisor or trainer may vary the approach to training staff, but at no time should the workbook be used as a self-study tool by direct support staff. The intent is for the supervisor/trainer to spend time with employees discussing the workbook content and issues related to the individuals they are supporting;
4. Documentation of administration of the workbook should be recorded on the Supervisor Assurance Certificate, kept on file, and available during a Utilization Review;
5. Documentation that staff reviewed and successfully completed the workbook should be recorded on the Direct Support Staff Assurance Certificate; and
6. It is not necessary for supervisors or staff to repeat their training if they change employment, but they may file a copy of the original certificate with successive employers.

DMAS will not contract directly with individuals to provide Personal Assistance or Respite services. Private agencies or CSBs may employ or contract with individuals who meet the requirements to provide Personal Assistance or Respite services, but must then have a Provider Agreement with DMAS to provide Personal Assistance or Respite services and bill for the services provided by those individuals.

Personal Assistance and Respite service providers may be related to an individual, but may not be spouses or parents of minor children. Payment will not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective, written documentation as to why there are no other providers available to provide the care. Family members who are approved to be reimbursed for providing this service must meet the assistant qualifications.

## **Exhibit D**

### **Companion Care Provider Requirements (Individuals who are Employed Under Agency and Consumer-Directed Models of Care)**

**Companion Provider Requirements.** The Companion must:

- Be at least 18 years of age;
- Possess basic reading, writing and math skills;
- Be capable of following a plan of care with minimal supervision;
- Submit to criminal history record check. The companion will not be compensated for services provided to the recipient or family/caregiver after the records check verifies the companion has been convicted of crimes described in the Code of Virginia, § 37.1-183.3 and § 37.1-197.2;
- Possess a valid Social Security number; and
- Be capable of instrumental activities of daily living.

Companions shall not be spouses. Payment will not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective, written documentation as to why there are no other providers available to provide the service.

#### **Additional Agency-Directed Requirements:**

Companions will be employees of agencies that will contract with DMAS to provide companion services. Agencies include personal care, home health agencies, and DMHMRSAS licensed providers of residential, day support, or respite services. Companion Care Agencies must comply with general provider requirements of all DMAS providers as specified in the Personal/Respite Provider Requirements in Exhibit D of Appendix B-2.

Agencies will be required to have a companion care supervisor to monitor companion care services. The supervisor must have a bachelor's degree in a human services field and at least one year of experience working in the mental retardation field, or be an LPN or an RN with at least one year of experience working in the mental retardation field. An LPN or RN must have a current license or certification to practice nursing in the Commonwealth of Virginia.

## **Exhibit E**

### **Personal Emergency Response Provider Requirements**

Personal Emergency Response System (PERS) provides the recipient with an electronic communications link with a monitoring agency which can arrange for the appropriate assistance when an emergency signal is received.

A PERS provider may be a certified home health or personal care agency, a long-term home health care program, a hospital, or any other entity capable of providing PERS services either directly or through subcontracts.

A PERS provider may also be a monitoring agency that is capable of receiving signals for help from a recipient's PERS equipment 24 hours a day, seven days per week; determining whether an emergency exists; and notifying an emergency response organization or an emergency responder that the PERS recipient needs emergency help.

A PERS provider must comply with all applicable Virginia Statutes and all applicable regulations of DMAS and all other governmental agencies having jurisdiction over the services to be performed.

The PERS provider is has the primary responsibility to furnish, install, maintain, test and service the PERS equipment as required, as well as to appropriately respond to signals for help.

- The PERS provider must properly install all PERS equipment into a PERS recipient's functioning telephone line and must furnish all supplies necessary for installing this equipment.
- A PERS provider must maintain all installed PERS equipment in proper working order.
- A PERS provider must maintain data record for each PERS recipient at no additional cost to DMAS.
- The PERS provider must provide an emergency response center staffed with trained emergency response operators available on a 24-hour basis, 365 days per year. The PERS provider must ensure that the monitoring agency is able to respond to the recipient when a recipient signals for help.
- Standards for PERS Equipment. All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard Number 1637, which is the UL safety standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The equipment shall be waterproof and be able to be worn by the recipient.

The emergency response activator must be activated either by breath, by touch, or by some other means and must be usable by persons who are visually or hearing impaired or physically disabled. The emergency response communicator must be capable of operating without external power during a power failure at the recipient's home in accordance with UL requirements for home health care signaling equipment with standby capability.

**Standards for Monitoring Agencies.** Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It is the PERS provider's responsibility to assure that the monitoring agency and the agency's equipment meets the following requirements. The monitoring agency must be capable of simultaneously responding to

multiple signals for help from the recipients' PERS equipment. The monitoring agency's equipment must include the following:

- A primary receiver and a back-up receiver, which must be independent and interchangeable;
- A back-up information retrieval system;
- A clock printer, which must print out the time and date of the emergency signal, the PERS recipient's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;
- A back-up power supply;
- A separate telephone service; and
- A telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and record keeping and reporting procedures. The agency must ensure 24 hour staffing of the monitoring agency and ensure that monitoring agency staff are fully trained regarding their responsibilities when the monitoring agency receives signals for help from a patient's PERS equipment. The monitoring agency staff will pass a written test administered by the provider pertaining to proper operation of the system and response to emergencies prior to being assigned to the agency.

#### C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

#### D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

## APPENDIX B-3 KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

### KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

### APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

\_\_\_\_\_ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

XX A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

#### Facility Type

#### Waiver Service(s)

1) Congregate Residential Setting: Residential Support, Skilled Nursing, Respite

2) ICF/MR Respite

## APPENDIX C-Eligibility and Post-Eligibility

### Appendix C-1--Eligibility

#### MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. (Check all that apply.)

1. XX Low income families with children as described in section 1931 of the Social Security Act.
2.      SSI recipients (SSI Rules States and 1634 States).
3. XX Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
4.      Optional State supplement recipients
5. XX Optional categorically needy aged and disabled who have income at (Check one):
  - a.      100% of the Federal poverty level (FPL)
  - b. 80 % Percent of FPL which is lower than 100%.
6. XX The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

XX A. Yes                           B. No

Check one:

  - a.      The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. XX Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) XX A special income level equal to:

XX 300% of the SSI Federal benefit (FBR)

    % of FBR, which is lower than 300% (42 CFR 435.236)

\$      which is lower than 300%

(2) XX Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)      Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435.324.)

(4)      Medically needy without spenddown in 209(b) States. (42 CFR 435.330)

(5) XX Aged and disabled who have income at:

a.      100% of the FPL

b. 80 % which is lower than 100%.

(6)      All other mandatory and optional groups under the plan are included.

(7)      Other (Include statutory reference only to reflect additional groups included under the State plan.)

7.      Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8.      All other mandatory and optional groups under the plan are included.

9.      Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

Appendix C-2--Post-Eligibility

REGULAR POST ELIGIBILITY

1. \_\_\_\_\_ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

A.     § 435.726--States which do not use more restrictive eligibility requirements than SSI.

a.     Allowances for the needs of the

1.     individual:     (Check one):

A.\_\_\_\_ The following standard included under the State plan  
(check one):

(1)\_\_\_\_ SSI

(2)\_\_\_\_ Medically needy

(3)\_\_\_\_ The special income level for the  
institutionalized

(4)\_\_\_\_ The following percent of the Federal  
poverty level): \_\_\_\_\_%

(5)\_\_\_\_ Other (specify):

B.\_\_\_\_ The following dollar amount:\$\_\_\_\_\*

\* If this amount changes, this item will be  
revised.

C.\_\_\_\_ The following formula is used to determine the  
needs allowance:

Note: If the amount protected for waiver recipients in item 1. is equal to, or greater than the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, enter NA in items 2. and 3. following.

2.     spouse only (check one):

A.\_\_\_\_ SSI standard

B.\_\_\_\_ Optional State supplement standard

C.\_\_\_\_ Medically needy income standard

D.\_\_\_\_ The following dollar amount:  
\$\_\_\_\_\_\*

\*If this amount changes, this item will be revised.

E.\_\_\_\_ The following percentage of the following standard that is  
not greater than the standards above: \_\_\_\_\_% of  
standard.

F.\_\_\_\_ The amount is determined using the following formula:

G.\_\_\_\_ Not applicable (N/A)

3. Family (check one):

A.\_\_\_\_ AFDC need standard

B.\_\_\_\_ AFDC payment standard

C.\_\_\_\_ Medically need income standard

D.\_\_\_\_ The following dollar amount: \$\_\_\_\_\_\*

\*If this amount changes, this item will be revised.

E.\_\_\_\_ The following percentage of the following standard that is  
not greater than the standards above: \_\_\_\_\_% of  
standard.

F.\_\_\_\_ The amount is determined using the following formula:

G. \_\_\_\_ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

## REGULAR POST ELIGIBILITY

1.(b) XX 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

B. 42 CFR 435.735--States using more restrictive requirements than SSI.

(a) Allowances for the needs of the

(1) individual: (check one):

A.      The following standard included under the State plan (check one):

(1)      SSI

(2)      Medically needy

(3)      The special income level for the  
institutionalized

(4)      The following percentage of the  
Federal poverty level:          %

(5)      Other (specify):

B.      The following dollar amount: \$          \*

\* If this amount changes, this item will be revised.

C. XX The following formula is used to determine the amount:

The basic maintenance needs for an individual is equal to the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least 8 but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic

allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

Note: If the amount protected for waiver recipients in 1. is equal to, or greater than the maximum amount of income a waiver recipient may have and be eligible under §435.217, enter NA in items 2. and 3. following.

2. spouse only (check one):

A.\_\_\_\_ The following standard under 42 CFR 435.121:

B.\_\_\_\_ The medically needy income standard\_\_\_\_;

C.\_\_\_\_ The following dollar amount: \$\_\_\_\_\*

\*If this amount changes, this item will be revised.

D.\_\_\_\_ The following percentage of the following standard that is not greater than the standards above:\_\_\_\_% of \_\_\_\_

E.\_\_\_\_ The following formula is used to determine the amount:

F. XX Not applicable (N/A)

3. family (check one):

A.\_\_\_\_ AFDC need standard

B.\_\_\_\_ AFDC payment standard

C. XX Medically needy income standard

D.\_\_\_\_ The following dollar amount: \$\_\_\_\_\*

\*If this amount changes, this item will be revised.

E.\_\_\_\_ The following percentage of the following standard that is not greater than the standards above: \_\_\_\_% of \_\_\_\_ standard.

F.\_\_\_\_ The following formula is used to determine the amount:

G.\_\_\_\_- Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

## SPOUSAL POST ELIGIBILITY

2. XX The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution towards the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual: (check one)

(1)      Institutional PNA: Specify the amount: \$           

\*Explain why you believe this amount is reasonable to meet the maintenance needs of the individual in the community:

(2) XX An amount which is comparable to the amount used as the maintenance allowance of the individual for home and community based waiver recipients who have no community spouses: (check one)

(a)      SSI Standard

(b)      Medically Needy Standard

(c)      The special income level for the institutionalized

(d)      The following percent of the Federal poverty level:      %

(spouse)      Other (specify):

(e)      The following dollar amount \$            \*\*

\*\*If this amount changes, this item will be revised.

(f) XX The following formula is used to determine the needs allowance:

The basic maintenance needs for an individual is equal to the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least 8 but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual

requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

## APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

### APPENDIX D-1 EVALUATION OF LEVEL OF CARE

- a.** The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

**b.** QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

\_\_\_ Discharge planning team

\_\_\_ Physician (M.D. or D.O.)

\_\_\_ Registered Nurse, licensed in the State

\_\_\_ Licensed Social Worker

\_\_\_ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

XX Other (Specify): Community Services Board/Behavioral Health Authority Case Manager

For Mental Retardation (MR) Case Management services to receive Medicaid reimbursement, the individual employed as a Case Manager must have, at entry level, qualifications that are documented or observable to include:

**A.** Knowledge of:

1. Services and systems available in the community including primary health care, support services, eligibility criteria and intake processes and generic community resources;
2. The nature of serious mental illness, mental retardation and/or substance abuse depending on the population served, including clinical and developmental issues;
3. Different types of assessments, including functional assessment, and their uses in service planning;
4. Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and services coordination;
5. Types of mental health, mental retardation and substance abuse programs available in the locality;
6. The service planning process and major components of a service plan;

7. The use of medications in the care or treatment of the population served; and
8. All applicable federal and state laws, state regulations and local ordinances.

B. Skills in:

1. Identifying and documenting an individual's need for resources, services, and other supports;
2. Using information from assessments, evaluations, observation, and interviews to develop service plans;
3. Identifying services and resources within the community and established service system to meet the individual's needs; and
4. Coordinating the provision of services by diverse public and private providers.

C. Abilities to:

1. Work as a team member, maintaining effective inter- and intra-agency working relationships;
2. Work independently performing position duties under general supervision; and
3. Engage and sustain ongoing relationships with individuals receiving services.

Individuals providing Targeted Case Management will be employed by organization that will be licensed by DMHMRSAS for Case Management services. If medical issues arise with recipients, case managers will be able to consult with RNs through the use of skilled nursing services.

The individual providing Targeted Case Management services is not required to be a member of an organizational unit that provides only case management. The case manager who is not a member of an organized case management unit must possess a job description that describes case management activities as job duties, must provide services as defined for Targeted Case Management services, and must comply with service expectations and documentation requirements as required for organized case management units. These standards are consistent between level of care reviewers for Virginia's community-based and Intermediate Care Facility for the Mentally Retarded services.

In addition, DMHMRSAS staff will perform a secondary review of level of care evaluations when pre-authorizations are requested for MR Waiver services. The DMHMRSAS staff meet QMRP requirements.

An individual cannot be a direct service provider and targeted case manager for the same recipient.

APPENDIX D-2      REEVALUATIONS OF LEVEL OF CARE

- a.      Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

\_\_\_      Every 3 months  
\_\_\_      Every 6 months  
XX      Every 12 months  
\_\_\_      Other (Specify):

- b.      QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

XX      The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.  
\_\_\_      The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):  
      \_\_\_      Physician (M.D. or D.O.)  
      \_\_\_      Registered Nurse, licensed in the State  
      \_\_\_      Social Worker  
      \_\_\_      Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)  
      \_\_\_      Other (Specify):

- c.      PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

\_\_\_      "Tickler" file  
\_\_\_      Edits in computer system  
XX      Component part of case management  
XX      Other (Specify): Sample level of care reviews will be monitored by DMAS staff assigned specifically to this program.

## APPENDIX D-3

### a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):
  - ☐ By the Medicaid agency in the Long-Term Care and Quality Assurance Division of its central office
  - ☐ By the Medicaid agency in district/local offices
  - ☒ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program (initial evaluations only)
  - ☒ By the Case Manager (initial evaluations and reevaluations)
  - ☐ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations
  - ☐ By service providers
  - ☐ Other (Specify):
2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

### b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

Attachment D:3-1 is the Level of Functioning Survey that is used to determine an individual's eligibility for ICF/MR placement and the MR Waiver. This document is used for the initial evaluation and reevaluation of the individual's level of care needs. For individuals under the age of 6, developmental milestones will also be used to help determine level of care needs. For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

- ☒ The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.
- ☐ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

## Attachment D-3:1

### Instructions for Completing MR Community Medicaid Waiver Level of Functioning Survey

For determining level of care eligibility for Mental Retardation Community Waiver services, consider the individual's functioning in community environments. Complete the attached survey presuming the needed services and supports are not in place for the individual. Please note that, for items in "Health Status" section, needed care or supervision may be provided by caregivers other than a licensed nurse.

#### **DEFINITIONS:**

***"No Assistance"*** means no help is needed.

***"Prompting/Structuring"*** means prior to the functioning, some verbal direction and/or some rearrangement of the environment is needed.

***"Supervision"*** means that a helper must be present during the functioning and provide only verbal direction, gestural prompts, and/or guidance.

***"Some Direct Assistance"*** means that a helper must be present and provide some physical guidance/support (with or without verbal direction).

***"Total Care"*** means that a helper must perform all or nearly all of the functions.

***"Rarely"*** means that the behavior occurs quarterly or less.

***"Sometimes"*** means that a behavior occurs once a month or less.

***"Often"*** means that a behavior occurs 2-3 times a month.

***"Regularly"*** means that a behavior occurs weekly or more.

MR COMMUNITY MEDICAID WAIVER  
LEVEL OF FUNCTIONING SURVEY  
SUMMARY SHEET

Consumer's Name: \_\_\_\_\_

*NOTE: The individual must meet the indicated dependency level in 2 or more of the following categories to justify need for services in a Medicaid-certified facility for persons with mental retardation or to meet level of care eligibility requirement for the Mental Retardation Community Waiver.*

Date: _____		Date: _____		Date: _____		
MET	NOT MET	MET	NOT MET	MET	NOT MET	See qualifying option in each category below:
						Category 1: Health Status  Two or more questions answered with a 4 or Question "j" answered yes.
						Category 2: Communication  Three or more questions answered with a 3 or 4
						Category 3: Task Learning Skills  Three or more questions answered with a 3 or 4
						Category 4: Personal/Self Care Question "a" answered with a 4 or 5 or Question "b" answered with a 4 or 5 or Question "c" and "d" answered with a 4 or 5
						Category 5: Mobility  Any one question answered with 4 or 5
						Category 6: Behavior  Any one question answered with a 3 or 4
						Category 7: Community Living Skills  Any two of questions "b", "e", or "g" answered with a 4 or 5 or Three or more questions answered with a 4 or 5

Date: \_\_\_\_\_ Evaluator's Signature: \_\_\_\_\_

Title/Affiliation: \_\_\_\_\_

Date: \_\_\_\_\_ Evaluator's Signature: \_\_\_\_\_

Title/Affiliation: \_\_\_\_\_

Date: \_\_\_\_\_ Evaluator's Signature: \_\_\_\_\_

Title/Affiliation: \_\_\_\_\_

Consumer's Name: \_\_\_\_\_

## LEVEL OF FUNCTIONING SURVEY

### 1. HEALTH STATUS

How often is nursing care or nursing supervision by a licensed nurse required for the following?  
(See instructions as it may also be provided by caregivers.)

*Please put appropriate number in the box under year of assessment.*

(Key: 1= Rarely, 2=Sometimes, 3=Often, and 4=Regularly)

	Date:	Date:	Date:
a.) Medication administration and/or evaluation for effectiveness of a medication regimen			
b.) Direct services: i.e., care for lesions, dressings, treatments, (other than shampoos, foot powder, etc.)			
c.) Seizure Control			
d.) Teaching diagnosed disease control and care, including diabetes			
e.) Management of care of diagnosed circulatory or respiratory problems			
f.) Motor disabilities which interfere with all activities of Daily Living - Bathing, Dressing, Mobility, Toileting, etc.			
g.) Observation for choking/aspiration while eating, drinking			
h.) Supervision of use of adaptive equipment, i.e., special spoon, braces, etc.			
i.) Observation for nutritional problems (i.e., undernourishment, swallowing difficulties, obesity)			
j.) Is age 55 or older, has a diagnosis of a chronic disease and has been in an institution 20 years or more			

Notes/Comments:

Consumer's Name: \_\_\_\_\_

## 2. COMMUNICATION

How often does this person:

*Please put appropriate number in the box under the year of assessment.*

( Key: 1=regularly, 2=often, 3=sometimes, 4=rarely)

Verbal Non-Verbal	Date:	Date:	Date:
a.) Indicate wants by pointing, vocal noises, or signs?			
b.) Use simple words, phrases, short sentences?			
c.) Ask for at least 10 things using appropriate names?			
d.) Understand simple words, phrases or instructions containing prepositions: i.e., "on", "in", "behind"?			
e.) Speak in an easily understood manner?			
f.) Identify self, place or residence, and significant others?			

Notes/Comments:

Consumer's Name: \_\_\_\_\_

### 3. TASK LEARNING SKILLS

How often does this person perform the following activities?

*Please put the appropriate number in the box under the year of assessment.*

( Key: 1=regularly, 2=often, 3=sometimes, 4=rarely )

	Date:	Date:	Date:
a.) Pay attention to purposeful activities for 5 minutes?			
b.) Stay with a 3-step task for more than 15 minutes?			
c.) Tell time to the hour and understand time intervals?			
d.) Count more than 10 objects?			
e.) Do simple addition, subtraction?			
f.) Write or print 10 words?			
g.) Discriminate shapes, sizes or colors?			
h.) Name people or objects when describing pictures?			
i.) Discriminate between "one", "many", "lot"?			

Notes/Comments:

Consumer's Name: \_\_\_\_\_

4. PERSONAL/SELF-CARE

With what type of assistance can this person currently:

*Please put appropriate number in the box under year of assessment*

(Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

	Date:	Date:	Date:
a.) Perform toileting functions i.e., maintain bladder and bowel continence, clean self, etc.?			
b.) Perform eating/feeding functions: i.e., drink liquids and eat with spoon or fork, etc.?			
c.) Perform bathing function: i.e., bathe, run bath, dry self, etc.?			
d.) Dress self completely, i.e., including fastening and putting on clothes?			

Notes/Comments:

Consumer's Name: \_\_\_\_\_

5. MOBILITY

With what type of assistance can this person currently:

*Please put appropriate number in the box under the year of assessment.*

(Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

Ambulatory Non-Ambulatory	Date:	Date:	Date:
a.) Move ( walking, wheeling) around environment?			
b.) Rise from lying down to sitting positions, sit without support?			
c.) Turn and position in bed, roll over?			

Notes/Comments:

Consumer's Name: \_\_\_\_\_

6. BEHAVIOR

How often does this person:

*Please put appropriate number in the box under the year of assessment .*

(Key: 1=Rarely, 2=Sometimes, 3=Often, 4=Regularly)

	Date:	Date:	Date:
a.) Engage in self-destructive behavior?			
b.) Threaten or do physical violence to others?			
c.) Throw things or damage property, have temper outbursts?			
d.) Respond to others in a socially unacceptable manner— (without undue anger, frustration or hostility)?			

Notes/Comments:

Consumer's Name: \_\_\_\_\_

7. COMMUNITY LIVING SKILLS

With what type of assistance would this person currently be able to:

*Please put appropriate number in the box under the year of assessment.*

(Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

	Date:	Date:	Date:
a.) Prepare simple foods requiring no mixing or cooking?			
b.) Take care of personal belongings, room (excluding vacuuming, ironing, clothes washing/drying, wet mopping)?			
c.) Add coins of various denominations up to one dollar?			
d.) Use telephone to call home, doctor, fire, police?			
e.) Recognize survival signs/words: i.e., stop, go, traffic lights, police, men, women, restrooms, danger, etc.?			
f.) Refrain from exhibiting unacceptable sexual behavior in public?			
g.) Go around cottage, ward, building, without running away, wandering off, or becoming lost?			
h.) Make minor purchases, i.e., candy, soft drinks, etc.?			

Notes/Comments:

## APPENDIX D-4

### a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:
  - a. informed of any feasible alternatives under the waiver; and
  - b. given the choice of either institutional or home and community-based services.

Individuals who choose to receive services within an ICF/MR will be provided these services in-state if available. If ICF/MR services are not available in-state, the individual will have the opportunity to receive services in a private ICF/MR located out of state.

If an individual is on the waiting list to receive MR Waiver services, the case manager will contact the consumer/family caregiver at least annually to provide the choice between institutional placement and waiver services and will have the consumer/family caregiver document their choice in Attachment D:4-1.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.
3. The following are attached to this Appendix: (Attachment D: 4-1)
  - a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;
  - b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;
  - c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and
  - d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

### b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

Freedom of choice is documented in the DCOUMENTATION OF RECIPIENT CHOICE form (Attachment D:4-2) and Choice of Providers form(Attachment D:4-3) and will be maintained by the Community Services Boards.

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Attachment D:4-1  
VIRGINIA ELIGIBILITY AND APPEALS

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Part I  
Client Appeals

Subpart I  
General

---

Article 1

*Definitions*

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12VAC30-110-10. Definitions.

The following words and terms, when used in these regulations, shall have the following meanings unless the context clearly indicates otherwise:

"Agency" means:

1. An agency which, on the department's behalf, makes determinations regarding applications for benefits provided by the department; and
2. The department itself.

"Appellant" means an applicant for or recipient of medical assistance benefits from the department who seeks to challenge an adverse action regarding his benefits or his eligibility for benefits.

"Department" means the Department of Medical Assistance Services.

"Division" means the department's Division of Client Appeals.

"Final decision" means a written determination by a hearing officer which is binding on the department, unless modified on appeal or review.

"Hearing" means the evidentiary hearing described in this regulation, conducted by a hearing officer employed by the department.

"Representative" means an attorney or agent who has been authorized to represent an appellant pursuant to these regulations.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 1.1; eff. October 1, 1993; amended, Virginia Register Volume 11, Issue 17, eff. June 15, 1995.

Effect of Amendment

The June 15, 1995, amendment deleted the definition of panel and effectively eliminated the availability of review by administrative law judges.

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*Article 2*  
*The Appeal System*

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**12VAC30-110-20. Division of Client Appeals.**

The division maintains an appeals system for appellants to challenge adverse actions regarding services and benefits provided by the department. Appellants shall be entitled to a hearing before a hearing officer. See Subpart II of these regulations.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 1.2; eff. October 1, 1993; amended, Virginia Register Volume 11, Issue 17, eff. June 15, 1995.

Effect of Amendment

The June 15, 1995, amendment deleted (former) subdivision 2.

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**12VAC30-110-30. Time limitation for appeals.**

Hearing officer appeals shall be scheduled and conducted to comply with the 90-day time limitation imposed by federal regulations, unless waived in writing by the appellant or the appellant's representative.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 1.3; eff. October 1, 1993; amended, Virginia Register Volume 11, Issue 17, eff. June 15, 1995.

Effect of Amendment

The June 15, 1995, amendment deleted a provision respecting final review.

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**12VAC30-110-40. Judicial review.**

An appellant who believes a final decision as defined herein is incorrect may seek judicial review pursuant to § 9-6.14:1 et seq. of the Code of Virginia and Part 2A, Rules of the Virginia Supreme Court.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 1.4; eff. October 1, 1993; amended, Virginia Register Volume 11, Issue 17, eff. June 15, 1995.

Effect of Amendment

The June 15, 1995, amendment deleted the review and decision process of the Medical Assistance Appeals Panel.

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*Article 3*  
*Representation*

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12VAC30-110-50. Right to representation.

An appellant shall have the full right to representation by an attorney or agent at all stages of appeal.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 1.5; eff. October 1, 1993.

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12VAC30-110-60. Designation of representative.

A. Agents. An agent must be designated in a written statement which is signed by the appellant. If the appellant is physically or mentally unable to sign a written statement, the division may allow a family member or other person acting on appellant's behalf to represent the appellant.

B. Attorneys. If the agent is an attorney or a paralegal working under the supervision of an attorney, a signed statement by such attorney or paralegal that he is authorized to represent the appellant prepared on the attorney's letterhead, shall be accepted as a designation of representation.

C. Substitution. A member of the same law firm as a designated representative shall have the same rights as the designated representative.

D. Revocation. An appellant may revoke representation by another person at any time. The revocation is effective when the department receives written notice from the appellant.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 1.6; eff. October 1, 1993.

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*Article 4*  
*Notice and Appeal Rights*

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**12VAC30-110-70. Notification of adverse agency action.**

The agency which makes an initial adverse determination shall inform the applicant or recipient in a written notice:

1. What action the agency intends to take;
2. The reasons for the intended action;
3. The specific regulations that support or the change in law that requires the action;
4. The right to request an evidentiary hearing, and the methods and time limits for doing so;
5. The circumstances under which benefits are continued if a hearing is requested (see 12VAC30-110-100); and
6. The right to representation.

**Statutory Authority**

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

**Historical Notes**

Derived from VR460-04-8.7 § 1.7; eff. October 1, 1993.

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**12VAC30-110-80. Advance notice.**

When the agency plans to terminate, suspend or reduce an individual's eligibility or covered services, the agency must mail the notice described in 12VAC30-110-70 at least 10 days before the date of action, except as otherwise permitted by federal law.

**Statutory Authority**

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

**Historical Notes**

Derived from VR460-04-8.7 § 1.8; eff. October 1, 1993.

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**12VAC30-110-90. Right to appeal.**

An individual has the right to file an appeal when:

1. His application for benefits administered by the department is denied. However, if an application for State Local Hospitalization coverage is denied because of a lack of funds which is confirmed by the hearing officer, there is no right to appeal.
2. The agency takes action or proposes to take action which will adversely affect, reduce, or terminate his receipt of benefits;
3. His request for a particular medical service is denied, in whole or in part;
4. The agency does not act with reasonable promptness on his application for benefits or request for a particular medical service; or
5. Federal regulations require that a fair hearing be granted.

**Statutory Authority**

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

**Historical Notes**

Derived from VR460-04-8.7 § 1.9; eff. October 1, 1993.

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**12VAC30-110-100. Maintaining services.**

A. If the agency mails the 10-day notice described in 12VAC30-110-80 and the appellant files his Request for Appeal before the date of action, his services shall not be terminated or reduced until the hearing officer issues a final decision unless it is determined at the hearing that the sole issue is one of federal or state law or policy and the appellant is promptly informed in writing that services are to be terminated or reduced pending the final decision.

B. If the agency's action is sustained on appeal, the agency may institute any available recovery procedures against the appellant to recoup the cost of any services furnished to the appellant, to the extent they were furnished solely by reason of subsection A of this section.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 1.10; eff. October 1, 1993.

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## *Article 5*

### *Miscellaneous Provisions*

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12VAC30-110-110. Division records.

A. Removal of records. No person shall take from the division's custody any original record, paper, document, or exhibit which has been certified to the division except as the Director of Client Appeals authorizes, or as may be necessary to furnish or transmit copies for other official purposes.

B. Confidentiality of records. Information in the appellant's record can be released only to a properly designated representative or other person(s) named in a release of information authorization signed by an appellant, his guardian or power of attorney.

C. Fees. The fees to be charged and collected for any copies will be in accordance with Virginia's Freedom of Information Act or other controlling law.

D. Waiver of fees. When copies are requested from records in the division's custody, the required fee shall be waived if the copies are requested in connection with an individual's own review or appeal.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 1.11; eff. October 1, 1993.

12VAC30-110-120. Computation of time limits.

A. Acceptance of postmark date. Documents postmarked on or before a time limit's expiration shall be accepted as timely.

B. Computation of time limit. In computing any time period under these regulations, the day of the act or event from which the designated period of time begins to run shall be excluded and the last day included. If a time limit would expire on a Saturday, Sunday, or state or federal holiday, it shall be extended until the next regular business day.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 1.12; eff. October 1, 1993.

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## Subpart II

### Hearing Officer Review

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## Article 1

### *Commencement of Appeals*

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12VAC30-110-130. Request for appeal.

Any written communication from an appellant or his representative which clearly expresses that he wants to present his case to a reviewing authority shall constitute an appeal request. This communication should explain the basis for the appeal.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 2.1; eff. October 1, 1993.

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12VAC30-110-140. Place of filing a Request for Appeal.

A Request for Appeal shall be delivered or mailed to the Division of Client Appeals.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 2.2; eff. October 1, 1993.

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12VAC30-110-150. Filing date.

The date of filing shall be the date the request is postmarked, if mailed, or the date the request is received by the department, if delivered other than by mail.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 2.3; eff. October 1, 1993.

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12VAC30-110-160. Time limit for filing.

A Request for Appeal shall be filed within 30 days of the appellant's receipt of the notice of an adverse action described in 12VAC30-110-70. It is presumed that appellants will receive the notice three days after the agency mails the notice. A Request for Appeal on the grounds that an agency has not acted with reasonable promptness may be filed at any time until the agency has acted.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 2.4; eff. October 1, 1993.

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12VAC30-110-170. Extension of time for filing.

An extension of the 30-day period for filing a Request for Appeal may be granted for good cause shown. Examples of good cause include, but are not limited to, the following situations:

1. Appellant was seriously ill and was prevented from contacting the division;
2. Appellant did not receive notice of the agency's decision;
3. Appellant sent the Request for Appeal to another government agency in good faith within the time limit;
4. Unusual or unavoidable circumstances prevented a timely filing.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

12VAC30-110-180. Provision of information.

Upon receipt of a Request for Appeal, the division shall notify the appellant and his representative of general appeals procedures and shall provide further detailed information upon request.

Statutory Authority  
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes  
Derived from VR460-04-8.7 § 2.6; eff. October 1, 1993.

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*Article 2*  
*Prehearing Review*

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12VAC30-110-190. Review.

A hearing officer shall initially review an assigned case for compliance with prehearing requirements and may communicate with the appellant or his representative and the agency to confirm the agency action and schedule the hearing.

Statutory Authority  
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes  
Derived from VR460-04-8.7 § 2.7; eff. October 1, 1993.

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12VAC30-110-200. Medical assessment.

A. A hearing officer may order an independent medical assessment when:

1. The hearing involves medical issues such as a diagnosis, an examining physician's report, or a medical review team's decision; and

2. The hearing officer determines it necessary to have an assessment by someone other than the person or team who made the original decision, for example, to obtain more detailed medical findings about the impairments, to obtain technical or specialized medical information, or to resolve conflicts or differences in medical findings or assessments in the existing evidence.

B. A medical assessment ordered pursuant to this regulation shall be at the department's expense and shall become part of the record.

Statutory Authority  
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes  
Derived from VR460-04-8.7 § 2.8; eff. October 1, 1993.

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12VAC30-110-210. Prehearing action.

A. Invalidation. A Request for Appeal may be invalidated if it was not filed within the time limit imposed by 12VAC30-110-160 or extended pursuant to 12VAC30-110-170.

1. If the hearing officer determines that the appellant has failed to file a timely appeal, the hearing officer shall notify the appellant and the appellant's representative of the opportunity to show good cause for the late appeal.

2. If a factual dispute exists about the timeliness of the Request for Appeal, the hearing officer shall receive evidence or testimony on those matters before taking final action.

3. If the individual filing the appeal is not the appellant or an authorized representative of the appellant under the provisions of 12VAC30-110-60 A, the appeal shall be determined invalid.

4. If a Request for Appeal is invalidated, the hearing officer shall issue a decision pursuant to 12VAC30-110-370.

B. Administrative dismissal. Request for Appeal may be administratively dismissed without a hearing if the appellant has no right to appeal under 12VAC30-110-90.

1. If the hearing officer determines that the appellant does not have the right to an appeal, the hearing officer shall issue a final decision dismissing the appeal and notify the appellant and appellant's representative of the opportunity to seek judicial review.

2. If a Request for Appeal is administratively dismissed, the hearing officer shall issue a decision pursuant to 12VAC30-110-370.

C. Judgment on the record. If the hearing officer determines from the record that the agency's determination was clearly in error and that the case should be resolved in the appellant's favor, he shall issue a decision pursuant to 12VAC30-110-370.

D. Remand to agency. If the hearing officer determines from the record that the case might be resolved in the appellant's favor if the agency obtains and develops additional information, documentation, or verification, he may remand the case to the agency for action consistent with the hearing officer's written instructions. The remand order shall be sent to the appellant and any representative.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 2.9; eff. October 1, 1993; amended, Virginia Register Volume 11, Issue 17, eff. June 15, 1995.

Effect of Amendment

The June 15, 1995, amendment deleted subsection E governing removal to the Medical Assistance Panel.

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*Article 3*  
*Hearing*

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**12VAC30-110-220. Evidentiary hearings.**

A hearing officer shall review all agency determinations which are properly appealed; conduct informal, fact-gathering hearings; evaluate evidence presented; and issue a written final decision sustaining, reversing, or remanding each case to the agency for further proceedings.

**Statutory Authority**

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

**Historical Notes**

Derived from VR460-04-8.7 § 2.10; eff. October 1, 1993.

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**12VAC30-110-230. Scheduling and rescheduling.**

A. To the extent possible, hearings will be scheduled at the appellant's convenience, with consideration of the travel distance required.

B. A hearing shall be rescheduled at the claimant's request no more than twice unless compelling reasons exist.

**Statutory Authority**

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

**Historical Notes**

Derived from VR460-04-8.7 § 2.11; eff. October 1, 1993; amended, Virginia Register Volume 11, Issue 17, eff. June 15, 1995.

**Effect of Amendment**

The June 15, 1995, amendment designated subsection A and added subsection B, former 12VAC30-110-240.

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**12VAC30-110-240. [Repealed]**

**Statutory Authority**

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

**Historical Notes**

Derived from VR460-04-8.7 § 2.11.1; eff. October 1, 1993; repealed, Virginia Register Volume 11, Issue 17, eff. June 15, 1995.

**Editor's Note**

The provisions of former 12VAC30-110-240 now appear in 12VAC30-110-230 B.

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**12VAC30-110-250. Notification.**

When a hearing is scheduled, the appellant and his representative shall be notified in writing of its time and place.

**Statutory Authority**

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

**Historical Notes**

Derived from VR460-04-8.7 § 2.12; eff. October 1, 1993.

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**12VAC30-110-260. Postponement.**

A hearing may be postponed for good cause shown. No postponement will be granted beyond 30 days after the date of the Request for Appeal was filed unless the appellant or his representative waives in writing the 90-day deadline for the final decision.

**Statutory Authority**

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

**Historical Notes**

12VAC30-110-270. Location.

The hearing location shall be determined by the division. If for medical reasons the appellant is unable to travel, the hearing may be conducted at his residence.

The agency may respond to a series of individual requests for hearings by conducting a single group hearing:

1. Only in cases in which the sole issue involved is one of federal or state law or policy; and
2. Each person must be permitted to present his own case or be represented by his authorized representative.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 2.14; eff. October 1, 1993.

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12VAC30-110-280. Client access to records.

Upon the request of the appellant or his representative, at a reasonable time before the date of the hearing, as well as during the hearing, the appellant and his representative may examine the content of appellant's case file and all documents and records the agency will rely on at the hearing.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 2.15; eff. October 1, 1993.

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#### 12VAC30-110-290. Subpoenas.

Appellants who require the attendance of witnesses or the production of records, memoranda, papers, and other documents at the hearing may request issuance of a subpoena in writing. The request must be received by the division at least five business days before the hearing is scheduled. Such request must include the witness' name, home and work address, county or city of work and residence, and identify the sheriff's office which will serve the subpoena.

##### Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

##### Historical Notes

Derived from VR460-04-8.7 § 2.16; eff. October 1, 1993.

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#### 12VAC30-110-300. Role of the hearing officer.

The hearing officer shall conduct the hearing, decide on questions of evidence, procedure and law, question witnesses, and assure that the hearing remains relevant to the issue or issues being appealed. The hearing officer shall control the conduct of the hearing and decide who may participate in or observe the hearing.

##### Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

##### Historical Notes

Derived from VR460-04-8.7 § 2.17; eff. October 1, 1993; amended, Virginia Register Volume 10, Issue 23, eff. October 1, 1994.

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#### 12VAC30-110-310. Informality of hearings.

Hearings shall be conducted in an informal, nonadversarial manner. The appellant or his representative has the right to bring witnesses, establish all pertinent facts and circumstances; present an argument without undue interference, and question or refute the testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

##### Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

##### Historical Notes

Derived from VR460-04-8.7 § 2.18; eff. October 1, 1993.

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#### 12VAC30-110-320. Evidence.

The rules of evidence shall not strictly apply. All relevant, nonrepetitive evidence may be admitted, but the probative weight of the evidence will be evaluated by the hearing officer.

##### Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

##### Historical Notes

Derived from VR460-04-8.7 § 2.19; eff. October 1, 1993.

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#### 12VAC30-110-330. Record of hearing.

All hearings shall be recorded either by court reporter, tape recorders, or whatever other means the agency deems appropriate. All exhibits accepted or rejected shall become part of the hearing record.

##### Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

##### Historical Notes

Derived from VR460-04-8.7 § 2.20; eff. October 1, 1993.

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#### 12VAC30-110-340. Oath or affirmation.

All witnesses shall testify under oath which shall be administered by the court reporter or the hearing officer, as delegated by the department's director.

##### Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

##### Historical Notes

Derived from VR460-04-8.7 § 2.21; eff. October 1, 1993.

#### 12VAC30-110-350. Dismissal of Request for Appeal.

Request for Appeal may be dismissed if:

1. The appellant or his representative withdraws the request in writing; or
2. The appellant or his representative fails to appear at the scheduled hearing without good cause, and does not reply within 10 days after the hearing officer mails an inquiry as to whether the appellant wishes further action on the appeal.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 2.22; eff. October 1, 1993.

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#### 12VAC30-110-360. Post-hearing supplementation of the record.

A. Medical assessment. Following a hearing, a hearing officer may order an independent medical assessment as described in 12VAC30-110-200.

B. Additional evidence. The hearing officer may leave the hearing record opened for a specified period of time in order to receive additional evidence or argument from the appellant. If the record indicates that evidence exists which was not presented by either party, with the appellant's permission, the hearing officer may attempt to secure such evidence.

C. Appellant's right to reconvene hearing or comment. If the hearing officer receives additional evidence from a person other than the appellant or his representative, the hearing officer shall send a copy of such evidence to the appellant and his representative and give the appellant the opportunity to comment on such evidence in writing or to reconvene the hearing to respond to such evidence.

D. Any additional evidence received will become a part of the hearing record, but the hearing officer must determine whether or not it will be used in making the decision.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 2.23; eff. October 1, 1993.

#### 12VAC30-110-370. Final decision.

After conducting the hearing, reviewing the record, and deciding questions of law, the hearing officer shall issue a written final decision which either sustains or reverses the agency action or remands the case to the agency for further action consistent with his written instructions. The hearing officer's final decision shall be considered as the agency's final administrative action pursuant to 42 CFR, 431.244(f). The final decision shall include:

1. A description of the procedural development of the case;
2. Findings of fact which identify supporting evidence;
3. Conclusions of law which identify supporting regulations and law;
4. Conclusions and reasoning;
5. The specific action to be taken by the agency to implement the decision; and
6. The notice shall state that a final decision may be appealed directly to circuit court as provided in § 9-6.14:16 B of the Code of Virginia and 12VAC30-110-40.

Statutory Authority

§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes

Derived from VR460-04-8.7 § 2.24; eff. October 1, 1993; amended, Virginia Register Volume 10, Issue 23, eff. October 1, 1994; amended, Virginia Register Volume 11, Issue 17, eff. June 15, 1995.

**DOCUMENTATION OF RECIPIENT CHOICE  
BETWEEN INSTITUTIONAL CARE OR HOME AND COMMUNITY-BASED  
SERVICES**

Recipient Name: \_\_\_\_\_

The following has been presented and discussed with the recipient and, if applicable, the parent, legal guardian or authorized representative (*please check*):

- ☐ The findings and results of the recipient's evaluations and stated needs;
- ☐ All MR Waiver services, including Consumer-Directed services;
- ☐ Plans for providing services to meet the recipient's needs;
- ☐ A choice between institutional care and MR Waiver services. Name the institutional care discussed:  
\_\_\_\_\_

- ☐ Information that the recipient may be placed on the Waiting List for both ICF-MR and MR Waiver services;
- ☐ Information that the recipient may be placed on the Statewide MR Waiver Waiting List and receive services in an ICF-MR at the same time;
- ☐ The recipient's right to a fair hearing and the appeal process.

The recipient and, if applicable, the parent, legal guardian or authorized representative, has:

\_\_\_\_\_ selected MR Waiver services (may require placement on the waiting list);

\_\_\_\_\_ selected ICF-MR services (may require placement on the waiting list); OR

\_\_\_\_\_ selected to be served in an ICF-MR or placed on an ICF-MR waiting list and be placed on the Statewide MR Waiver Waiting List at the same time.

\_\_\_\_\_  
Signature of Recipient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent, Legal Guardian, Authorized  
Representative (underline applicable designation)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Case Manager

\_\_\_\_\_  
Date

DMAS 459-C 10/03

## **VIRGINIA HOME AND COMMUNITY BASED WAIVER CHOICE OF PROVIDERS \*\***

I have reviewed information about and/or visited the sites of the providers available under the Home and Community-Based Waiver for Mental Retardation Services, as listed on the MR Waiver Provider Roster provided by DMHMRSAS, in the location(s) of my choice. I have freely chosen services based upon my needs and interests. I am aware of the fact that I may contact my case manager at any point in the future to discuss concerns that I cannot resolve, with the option of changing Waiver providers. I have selected the following provider(s):

### **PROVIDER NAME**

### **TYPE OF MR WAIVER SERVICE**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**\*\*Choice must be documented when Waiver services are initiated, when there is a request for a change in provider(s), when additional services are initiated, or when a consumer is dissatisfied with the current provider.**

\_\_\_\_\_  
Individual/Legal Guardian Signature & Date

\_\_\_\_\_  
Case Manager Signature & Date

\_\_\_\_\_  
Authorized Representative Signature & Date

## APPENDIX E - PLAN OF CARE

### APPENDIX E-1

#### a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the consumer service plans:

☐ Registered nurse, licensed to practice in the State

☐ Licensed practical or vocational nurse, acting within the scope of practice under State law

☐ Physician (M.D. or D.O.) licensed to practice in the State

☐ Social Worker

☒ Case manager

☐ Other (specify):

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

☐ At the Medicaid agency central office

☐ At the Medicaid agency county/regional offices

☒ By Case managers

☒ By the agency specified in Appendix A

☒ By consumers (For informational purposes only; will not be required to keep for three years)

☐ Other (specify):

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the

appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

- ☒ Every 3 months (quarterly face-to-face visits by the case manager and the recipient)
- ☐ Every 6 months
- ☒ Every 12 months (annual review by the case manager, the recipient, and providers)
- ☐ Other (specify):

## APPENDIX E-2

### a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

All individuals gain access to Mental Retardation Waiver services through the local Community Services Board (CSB). The CSB initiates State Plan targeted case management services, determines need and eligibility for MR Waiver services, and submits enrollment and authorization requests to DMHMRSAS. Final recommendation for authorization of MR Waiver services is the responsibility of DMHMRSAS, upon recommendation from the Case Management provider and review of the documentation materials. DMAS has the final authority on all approvals.

DMAS will review approximately 10% of all pre authorizations conducted by DMHMRSAS to ensure the appropriateness of the authorizations. This will include approved, pended and denied pre-authorization requests.

### b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care summary form to be utilized in this waiver is attached to this Appendix. (Attachment E:2-1. The Plan of Care Summary is only two pages, but due to formatting difficulties with this template, the document was split into three pages.)

Attachment E:2-1

Department of Mental Health, Mental Retardation and Substance Abuse Services

MR WAIVER PLAN OF CARE SUMMARY

Individual's Name:	<input type="text"/>	<input type="text"/>	<input type="text"/>	CSP Start Date:	<input type="text"/>
	LAST	FIRST	M.I.		
Medicaid Number:	<input type="text"/>	Date of last medical exam:	<input type="text"/>	CSP End Date:	<input type="text"/>
CSB:	<input type="text"/>	Case Manager:	<input type="text"/>	Phone:	<input type="text"/>

Primary goals of the individual:

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---

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Living Arrangements (while in the MR Waiver)

Check any that apply:

- ☐ Lives alone
- ☐ In home/apartment shared with relatives or other
- ☐ DMHMRSAS-Licensed Supportive Residential
- ☐ DMHMRSAS-Licensed Group Home (2-4 persons)
- ☐ DMHMRSAS-Licensed Group Home (5 or more)
- ☐ DMHMRSAS-Licensed Sponsored Placement
- ☐ DSS-Approved Adult Foster/Family Care Home
- ☐ DSS-Licensed Assisted Living Facility
- ☐ DSS-Approved Child Foster Care Home
- ☐ Core-Licensed Children's Family Care Home
- ☐ Core-Licensed Children's Group Home
- ☐ Other (specify):

ICF/MR Level of Functioning  Date completed

Check the following categories in which dependency level is met (must be met in 2 or more within 6 months of start date)

- |  |   |
|--|---|
| <input type="checkbox"/> 1. Health Status        | <input type="checkbox"/> 5. Mobility                |
| <input type="checkbox"/> 2. Communication        | <input type="checkbox"/> 6. Behavior                |
| <input type="checkbox"/> 3. Task Learning Skills | <input type="checkbox"/> 7. Community Living Skills |
| <input type="checkbox"/> 4. Personal/Self Care   |   |

ICAP\*

GMI

Date Completed:

Service Score

\*Attach other assessment summary if ICAP not used

**List the full range of services/supports that this individual receives/will receive:**

Service Type	Services/Supports	Provider Name	Amt / Frequency	Start Date
<b>WAIVER SERVICES</b>				
Case Management				
<b>If more than one provider, enter 2nd here</b> <b>Residential Support</b> →	In-Home/Supported Living			
	Group Home			
	Group Home for Children			
	AFC			
	Sponsored Placement			
<b>If more than one provider, enter 2nd here</b> <b>Day Support</b> →	Regular Intensity, Center-Based			
	Regular Intensity, Community-Based			
	High Intensity, Center-Based			
	High Intensity, Community-Based			
<b>If more than one provider, enter 2nd here</b> <b>Prevocational</b> →	Regular Intensity, Center-Based			
	Regular Intensity, Community-Based			
	High Intensity, Center-Based			
	High Intensity, Community-Based			
Individual's Name:	LAST	FIRST	M.I.	Medicaid #:

Service Type	Services/Supports	Provider Name	Amt / Frequency	Start Date
<b>WAIVER SERVICES (continued)</b>				
<b>Supported Employment</b> <b>If more than one provider, enter 2nd here</b> →	Individual Placement			
	Group			
<b>Personal Assistance</b>	Agency Directed			
	Consumer Directed			
<b>Skilled Nursing</b> <b>If more than one provider enter 2nd here</b> →	LPN			
	RN			
<b>If more than one provider enter 2nd here</b> <b>Respite</b> →	In-Home			
	Out-of-Home			
	Residential			
	Center-Based			
	Consumer Directed			

Companion	Agency Directed			
	Consumer Directed			
Therapeutic Consultation	Behavioral			
	Psychological			
	Physical			
	Speech			
	Occupational			
	Recreational			
	Rehabilitation Engineering			
Crisis Stabilization	Clinical / Behavioral Intervention			
	Crisis Supervision			
Environmental Modification				
Assistive Technology				
PERS (Personal Emergency Response System)	PERS			
	PERS and Medication Monitoring			
School				
Medical				
Mental Health				
OT/PT/SP Therapy				
Other				

**ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.**

\_\_\_\_\_  
Case Manager Signature

\_\_\_\_\_  
Date

## APPENDIX F - AUDIT TRAIL

### *a.* DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.
2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

\_\_\_\_\_ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

XX Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix (Attachment F-1).

\_\_\_\_\_ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

\_\_\_\_\_ Other (Describe in detail):

## **Attachment F-1**

### **Manual Payments for Certain MR Waiver Services**

For the Mental Retardation (MR) Waiver procedures listed below, the Department of Medical Assistance Services (DMAS) is currently processing the claims payment manually. This manual process is being carried out due to the implementation and certification of the new Virginia Medicaid Management Information System (VaMMIS). VaMMIS implementation has prevented DMAS from implementing any new services for automated claims processing until the VAMMIS system is certified by the Centers for Medicare and Medicaid Services (CMS). The current manual process is carried out by one fiscal technician in the Customer Services Unit, within the Division of Program Support. Prior to any claims being paid by First Health Services Corporation (FHSC), all claims payments are reviewed by the Customer Services Supervisor and Manager as an audit control. The APA carries out an audit of all of the services provided to Medicaid clients enrolled in the Mental Retardation Waiver, including the services listed below that are processed manually.

Procedures are in place to make sure that the provider offering the service is eligible, that the client is eligible, that the services was authorized, that the correct payment is made and that duplicate payments are not paid. All files are kept at DMAS and are available for inspection. All claims payments are logged into an ACCESS database for appropriate CMS reporting purposes.

#### ***MR Services Paid Off-line***

- Service Facilitation services for Consumer-directed services
- Pre-Vocational Services
- Companion Services

#### ***Claims Processing Procedures***

1. Verify Recipient and Provider Eligibility in VaMMIS (print screens and place in paper file)
2. Verify eligibility for recipient to receive specific service and provider to provide specific service – VAMMIS and PA contractor documentation if relevant (print screens and place in paper file)
3. Determine specific claim limits for service performed – document Paper File
4. Check for claim duplication edits and Preauthorization of services– check Paper File
5. Check procedure code for correct claim payment amount – check MR Waiver manual
6. Multiply claim payment amount by amount of services performed/Document calculation – Document in Paper File
7. Key in relevant information into Add Pay Off-Line Access Database (Database is organized by provider ID number, procedure code, date of service and patient ID/Name)

8. Complete check request form to the Fiscal Division – Copy in Paper File
9. Upon receipt of check, generate manual remittance that includes patient names and numbers, dates of service, claims payment amount, balance of pre-authorized service after claims payment.
10. Mail check and remittance to the provider, file and retain a paper copy
11. Document paper claim file with information obtained (retain paper file for a minimum of 4 years)

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:
  - a. When the individual was eligible for Medicaid waiver payment on the date of service;
  - b. When the service was included in the approved plan of care;
  - c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.  
  
XX Yes  
  
\_\_\_\_ No. These services are not included in this waiver.
2. The following is a description of all records maintained in connection with an audit trail. Check one:  
  
\_\_\_\_ All claims are processed through an approved MMIS.  
  
XX MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found (See Attachment F-1).
3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

☐ The Medicaid agency will make payments directly to providers of waiver services.

☒ The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

☒ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims for Consumer-Directed Services. The claim information, however, will still be captured in the MMIS system for reporting requirements to CMS.

☐ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

## APPENDIX G - FINANCIAL DOCUMENTATION

### APPENDIX G-1

#### COMPOSITE OVERVIEW - COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: ICF/MR

<u>YEAR</u>	<u>FACTOR D</u>	<u>FACTOR D'</u>	<u>FACTOR G</u>	<u>FACTOR G'</u>
1. FY05	\$39,946	\$ 9,143	\$115,515	\$4,376
2 FY06	\$41,193	\$ 9,617	\$123,182	\$4,625
3 FY07	\$41,193	\$10,115	\$131,358	\$4,888
4 FY08	\$41,193	\$10,640	\$140,077	\$5,166
5 FY09	\$41,193	\$11,191	\$149,374	\$5,460

*Calculations and projections are based on historical trends and utilization patterns. FY 2005 reflects the addition of 860 slots and a 0.4 percent rate increase for all services except personal care. FY 2006 reflects the addition of 180 slots and a five-percent rate increase for personal care services and a three-percent increase for all other services.*

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

<u>YEAR</u>	<u>UNDUPLICATED INDIVIDUALS</u>
1 FY05	6,571
2 FY06	6,751
3 FY07	6,751
4 FY08	6,751
5 FY09	6,751

EXPLANATION OF FACTOR C:

Check one:

☐ The State will make waiver services available to individual in the target group up to the number indicated as fact C for the waiver year.

☒ The State will make waiver services available to individuals in the target group up to the lesser number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform CMS in writing of any limit that is less than factor C for that waiver year.

APPENDIX G-2  
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

APPENDIX G-2  
 FACTOR D  
 LOC: ICF/MR

WAIVER YEAR 1: FY 2005

WAIVER SERVICE	# UNDUP RECIPIENTS	AVG # ANNUAL UNITS/USER	AVG UNIT COST	TOTAL
DAY SUPPORT	4,659	375 units/year	\$31.28	\$54,650,070
SUPPORTED EMPLOYMENT	437	305 units/year	\$32.02	\$4,267,786
CONGREGATE RESIDENTIAL	3,462	3,697 hours/year	\$12.86	\$164,595,320
IN-HOME RESIDENTIAL	1,218	904 hours/year	\$18.07	\$19,896,371
THERAPEUTIC CONS	582	13 hours/year	\$50.20	\$379,813
PERSONAL CARE	398	1,371 hours/year	\$11.87	\$6,476,960
RESPIRE SERVICES	599	252 hours/year	\$11.87	\$1,791,753
SKILLED NURSING	72	1,252 hours/year	\$22.87	\$2,061,593
CRISIS STABILIZATION	25	247 hours/year	\$32.34	\$199,700
ENVIRONMENTAL MOD	53	1 unit/year	\$3,344	\$177,232
ASSISTIVE TECHNOLOGY	69	1 unit/year	\$1,157	\$79,833
PERS/INSTALL	6	1 unit/year	\$52.21	\$313
PERS/MONTHLY	6	11 mths/year	\$31.12	\$2,054
MED MONITORING/INSTALL	1	1 unit/year	\$78.31	\$78
MED MONITORING/MONTHLY	1	11 mths/year	\$52.21	\$574
COMPANION SERVICES	40	24 hours/year	\$11.87	\$11,395
PREVOCATIONAL SRVCS	2,874	30 units/year	\$31.28	\$2,696,962
FACILITATOR	554	4 units/year	\$90.10	\$199,662
CD PERSONAL CARE	345	1,162 hours/year	\$8.38	\$3,359,458
CD RESPIRE	417	363 hours/year	\$8.38	\$1,268,489
CD COMPANION SERVICES	69	639 hours/year	\$8.38	\$369,483
GRAND TOTAL OF WAIVER COSTS				\$262,484,899

NUMBER OF UNDUPLICATED WAIVER RECIPS	6,571
FACTOR D (DIVIDE TOTAL BY NUMBER OF RECIPIENTS)	\$39,946

AVERAGE LENGTH OF STAY DURING WAIVER YEAR	352
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APPENDIX G-2  
 FACTOR D  
 LOC: ICF/MR

WAIVER YEAR 2: FY 2006

WAIVER SERVICE	# UNDUP RECIPIENTS	AVG # ANNUAL UNITS/USER	AVG UNIT COST	TOTAL
DAY SUPPORT	4,786	375 units/year	\$32.22	\$57,826,845
SUPPORTED EMPLOYMENT	449	305 units/year	\$32.98	\$4,516,446
CONGREGATE RESIDENTIAL	3,557	3,697 hours/year	\$13.25	\$174,240,534
IN-HOME RESIDENTIAL	1,251	904 hours/year	\$18.61	\$21,046,123
THERAPEUTIC CONS	598	13 hours/year	\$51.71	\$401,994
PERSONAL CARE	409	1,371 hours/year	\$12.46	\$6,986,808
RESPIRE SERVICES	616	252 hours/year	\$12.46	\$1,934,191
SKILLED NURSING	74	1,252 hours/year	\$23.56	\$2,182,426
CRISIS STABILIZATION	26	247 hours/year	\$33.31	\$213,917
ENVIRONMENTAL MOD	55	1 unit/year	\$3,344	\$183,920
ASSISTIVE TECHNOLOGY	71	1 unit/year	\$1,157	\$82,147
PERS/INSTALL	6	1 unit/year	\$53.78	\$323
PERS/MONTHLY	6	11 mths/year	\$32.05	\$2,115
MED MONITORING/INSTALL	1	1 unit/year	\$80.66	\$81
MED MONITORING/MONTHLY	1	11 mths/year	\$53.78	\$592
COMPANION SERVICES	41	24 hours/year	\$12.46	\$12,261
PREVOCATIONAL SRVCS	2,952	30 units/year	\$32.22	\$2,853,403
FACILITATOR	569	4 units/year	\$92.80	\$211,213
CD PERSONAL CARE	355	1,162 hours/year	\$8.80	\$3,630,088
CD RESPIRE	428	363 hours/year	\$8.80	\$1,367,203
CD COMPANION SERVICES	71	639 hours/year	\$8.80	\$399,247
GRAND TOTAL OF WAIVER COSTS				\$278,091,876

NUMBER OF UNDUPLICATED WAIVER RECIPS	6,751
FACTOR D (DIVIDE TOTAL BY NUMBER OF RECIPIENTS)	\$41,193

AVERAGE LENGTH OF STAY DURING WAIVER YEAR	352
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APPENDIX G-2  
 FACTOR D  
 LOC: ICF/MR

WAIVER YEAR 3: FY 2007

WAIVER SERVICE	# UNDUP RECIPIENTS	AVG # ANNUAL UNITS/USER	AVG UNIT COST	TOTAL
DAY SUPPORT	4,786	375 units/year	\$32.22	\$57,826,845
SUPPORTED EMPLOYMENT	449	305 units/year	\$32.98	\$4,516,446
CONGREGATE RESIDENTIAL	3,557	3,697 hours/year	\$13.25	\$174,240,534
IN-HOME RESIDENTIAL	1,251	904 hours/year	\$18.61	\$21,046,123
THERAPEUTIC CONS	598	13 hours/year	\$51.71	\$401,994
PERSONAL CARE	409	1,371 hours/year	\$12.46	\$6,986,808
RESPIRE SERVICES	616	252 hours/year	\$12.46	\$1,934,191
SKILLED NURSING	74	1,252 hours/year	\$23.56	\$2,182,426
CRISIS STABILIZATION	26	247 hours/year	\$33.31	\$213,917
ENVIRONMENTAL MOD	55	1 unit/year	\$3,344	\$183,920
ASSISTIVE TECHNOLOGY	71	1 unit/year	\$1,157	\$82,147
PERS/INSTALL	6	1 unit/year	\$53.78	\$323
PERS/MONTHLY	6	11 mths/year	\$32.05	\$2,115
MED MONITORING/INSTALL	1	1 unit/year	\$80.66	\$81
MED MONITORING/MONTHLY	1	11 mths/year	\$53.78	\$592
COMPANION SERVICES	41	24 hours/year	\$12.46	\$12,261
PREVOCATIONAL SRVCS	2,952	30 units/year	\$32.22	\$2,853,403
FACILITATOR	569	4 units/year	\$92.80	\$211,213
CD PERSONAL CARE	355	1,162 hours/year	\$8.80	\$3,630,088
CD RESPIRE	428	363 hours/year	\$8.80	\$1,367,203
CD COMPANION SERVICES	71	639 hours/year	\$8.80	\$399,247
GRAND TOTAL OF WAIVER COSTS				\$278,091,876

NUMBER OF UNDUPLICATED WAIVER RECIPS	6,751
FACTOR D (DIVIDE TOTAL BY NUMBER OF RECIPIENTS)	\$41,193

AVERAGE LENGTH OF STAY DURING WAIVER YEAR	352
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APPENDIX G-2  
 FACTOR D  
 LOC: ICF/MR

WAIVER YEAR 4: FY 2008

WAIVER SERVICE	# UNDUP RECIPIENTS	AVG # ANNUAL UNITS/USER	AVG UNIT COST	TOTAL
DAY SUPPORT	4,786	375 units/year	\$32.22	\$57,826,845
SUPPORTED EMPLOYMENT	449	305 units/year	\$32.98	\$4,516,446
CONGREGATE RESIDENTIAL	3,557	3,697 hours/year	\$13.25	\$174,240,534
IN-HOME RESIDENTIAL	1,251	904 hours/year	\$18.61	\$21,046,123
THERAPEUTIC CONS	598	13 hours/year	\$51.71	\$401,994
PERSONAL CARE	409	1,371 hours/year	\$12.46	\$6,986,808
RESPIRE SERVICES	616	252 hours/year	\$12.46	\$1,934,191
SKILLED NURSING	74	1,252 hours/year	\$23.56	\$2,182,426
CRISIS STABILIZATION	26	247 hours/year	\$33.31	\$213,917
ENVIRONMENTAL MOD	55	1 unit/year	\$3,344	\$183,920
ASSISTIVE TECHNOLOGY	71	1 unit/year	\$1,157	\$82,147
PERS/INSTALL	6	1 unit/year	\$53.78	\$323
PERS/MONTHLY	6	11 mths/year	\$32.05	\$2,115
MED MONITORING/INSTALL	1	1 unit/year	\$80.66	\$81
MED MONITORING/MONTHLY	1	11 mths/year	\$53.78	\$592
COMPANION SERVICES	41	24 hours/year	\$12.46	\$12,261
PREVOCATIONAL SRVCS	2,952	30 units/year	\$32.22	\$2,853,403
FACILITATOR	569	4 units/year	\$92.80	\$211,213
CD PERSONAL CARE	355	1,162 hours/year	\$8.80	\$3,630,088
CD RESPIRE	428	363 hours/year	\$8.80	\$1,367,203
CD COMPANION SERVICES	71	639 hours/year	\$8.80	\$399,247
GRAND TOTAL OF WAIVER COSTS				\$278,091,876

NUMBER OF UNDUPLICATED WAIVER RECIPS	6,751
FACTOR D (DIVIDE TOTAL BY NUMBER OF RECIPIENTS)	\$41,193

AVERAGE LENGTH OF STAY DURING WAIVER YEAR	352
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APPENDIX G-2  
 FACTOR D  
 LOC: ICF/MR

WAIVER YEAR 5: FY 2009

WAIVER SERVICE	# UNDUP RECIPIENTS	AVG # ANNUAL UNITS/USER	AVG UNIT COST	TOTAL
DAY SUPPORT	4,786	375 units/year	\$32.22	\$57,826,845
SUPPORTED EMPLOYMENT	449	305 units/year	\$32.98	\$4,516,446
CONGREGATE RESIDENTIAL	3,557	3,697 hours/year	\$13.25	\$174,240,534
IN-HOME RESIDENTIAL	1,251	904 hours/year	\$18.61	\$21,046,123
THERAPEUTIC CONS	598	13 hours/year	\$51.71	\$401,994
PERSONAL CARE	409	1,371 hours/year	\$12.46	\$6,986,808
RESPIRE SERVICES	616	252 hours/year	\$12.46	\$1,934,191
SKILLED NURSING	74	1,252 hours/year	\$23.56	\$2,182,426
CRISIS STABILIZATION	26	247 hours/year	\$33.31	\$213,917
ENVIRONMENTAL MOD	55	1 unit/year	\$3,344	\$183,920
ASSISTIVE TECHNOLOGY	71	1 unit/year	\$1,157	\$82,147
PERS/INSTALL	6	1 unit/year	\$53.78	\$323
PERS/MONTHLY	6	11 mths/year	\$32.05	\$2,115
MED MONITORING/INSTALL	1	1 unit/year	\$80.66	\$81
MED MONITORING/MONTHLY	1	11 mths/year	\$53.78	\$592
COMPANION SERVICES	41	24 hours/year	\$12.46	\$12,261
PREVOCATIONAL SRVCS	2,952	30 units/year	\$32.22	\$2,853,403
FACILITATOR	569	4 units/year	\$92.80	\$211,213
CD PERSONAL CARE	355	1,162 hours/year	\$8.80	\$3,630,088
CD RESPIRE	428	363 hours/year	\$8.80	\$1,367,203
CD COMPANION SERVICES	71	639 hours/year	\$8.80	\$399,247
GRAND TOTAL OF WAIVER COSTS				\$278,091,876

NUMBER OF UNDUPLICATED WAIVER RECIPS	6,751
FACTOR D (DIVIDE TOTAL BY NUMBER OF RECIPIENTS)	\$41,193

AVERAGE LENGTH OF STAY DURING WAIVER YEAR	352
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APPENDIX G-3  
METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care\*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

- \* Assistive Technology
- \* Companion services (agency and consumer-directed)
- \* Congregate Residential Supports
- \* Crisis Stabilization
- \* Environmental Modifications
- \* Personal Assistance (agency and consumer-directed)
- \* Therapeutic Consultation

\*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Not applicable

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board (Attachment G:3-1)

## **Waiver Services in Relation to Room and Board Payment**

The amount of waiver services a recipient is authorized to receive is based on documentation that demonstrates the adequacy and appropriateness of the services with regard to the recipient's current functioning, cognitive status, health, safety and social needs. The Department of Medical Assistance Services pays providers an established rate to cover the costs of providing waiver services to the recipient. Rates are not intended to cover the costs of room and board. Providers are only allowed to bill for allowable activities described for each waiver service, and room and board is not an allowable activity.

Generally, the fees collected from federal benefits (SSI, SSA, SSDI, Railroad Retirement, etc.) cover the costs of room and board for residential placements. If not, providers use other sources of revenue to cover the remainder. Other revenue sources that are used include:

- \* Private pay fees;
- \* Fees from consulting, training, other contractual services;
- \* Charitable Sources (Endowments, Organization or Private Foundations, United Way, Fundraising efforts)
- \* HUD 811 and Section 8 programs; and
- \* State General funding and Local funding.

APPENDIX G-4

METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED  
LIVE-IN CAREGIVER

Check one:

XX The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

\_\_\_\_\_ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

## APPENDIX G-5

### FACTOR D'

LOC: ICF/MR

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services **WHILE THE INDIVIDUAL WAS ON THE WAIVER.**

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began **AFTER** the person's first day of waiver services and ended **BEFORE** the end of the waiver year **IF** the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred **BEFORE** the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR D' (cont.)

LOC: ICF/MR

Factor D' is computed as follows (check one):

☐ Based on HCFA Form 2082 (relevant pages attached).

☒ Based on HCFA Form 372 for years 2001,2002 & 2003 of waiver  
# 0372.02, which serves a similar target population.

☐ Based on a statistically valid sample of plans of care for individuals with the disease or condition  
specified in item 3 of this request.

☐ Other (specify):

## APPENDIX G-6

### FACTOR G

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

- ☐ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.
- ☒ Based on trends shown by HCFA Form 372 for years 2001, 2002, & 2003 of waiver # 0372.02, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.
- ☐ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.
- ☐ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.
- ☐ Other (specify):

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

## APPENDIX G-7

### FACTOR G'

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPENDIX G-7

FACTOR G'

LOC: ICF/MR

Factor G' is computed as follows (check one):

☐ Based on HCFA Form 2082 (relevant pages attached).

☒ Based on HCFA Form 372 for years 2001, 2002, 2003 of waiver  
# 0372.02, which serves a similar target population.

☐ Based on a statistically valid sample of plans of care for individuals with the disease or  
condition specified in item 3 of this request.

☐ Other (specify):

APPENDIX G-8  
 DEMONSTRATION OF COST NEUTRALITY  
 LOC: ICF/MR

YEAR 1, FY 2005

FACTOR D:	\$39,946		FACTOR G:	\$115,515
FACTOR D':	<u>\$9,143</u>		FACTOR G':	<u>\$4,376</u>
TOTAL:	\$49,089	<	TOTAL:	<u>\$119,891</u>

YEAR 2, FY 2006

FACTOR D:	\$41,193		FACTOR G:	\$123,182
FACTOR D':	<u>\$9,617</u>		FACTOR G':	<u>\$4,625</u>
TOTAL:	\$50,810	<	TOTAL:	<u>\$127,807</u>

YEAR 3, FY 2007

FACTOR D:	\$41,193		FACTOR G:	\$131,358
FACTOR D':	<u>\$10,115</u>		FACTOR G':	<u>\$4,888</u>
TOTAL:	\$51,308	<	TOTAL:	<u>\$136,246</u>

YEAR 4, FY 2008

FACTOR D:	\$41,193		FACTOR G:	\$140,077
FACTOR D':	<u>\$10,640</u>		FACTOR G':	<u>\$5,166</u>
TOTAL:	\$51,832	<	TOTAL:	<u>\$145,243</u>

YEAR 5, FY 2009

FACTOR D:	\$41,193		FACTOR G:	\$149,374
FACTOR D':	\$11,191		FACTOR G':	\$5,460
TOTAL:	<u>\$52,384</u>	<	TOTAL:	<u>\$154,834</u>